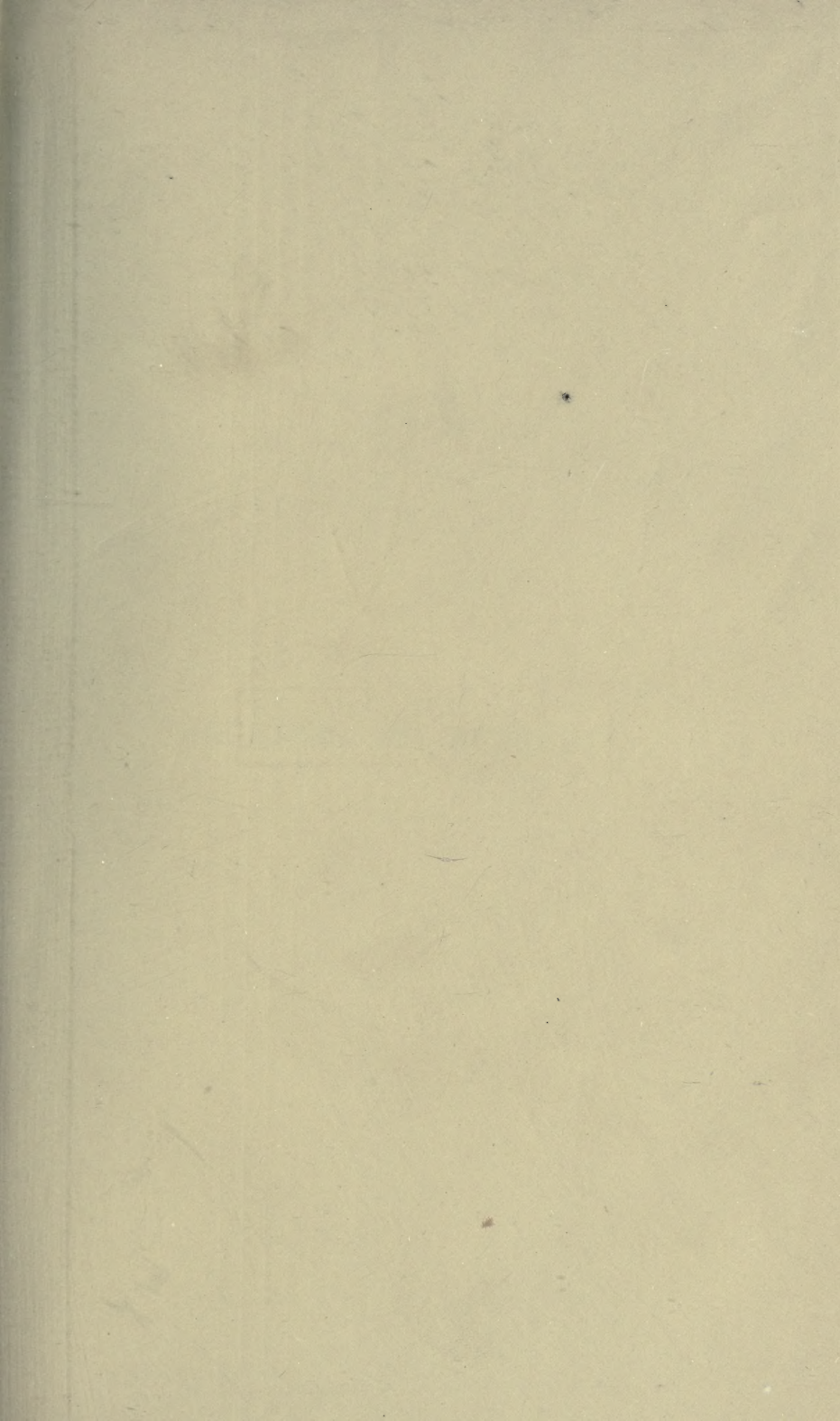
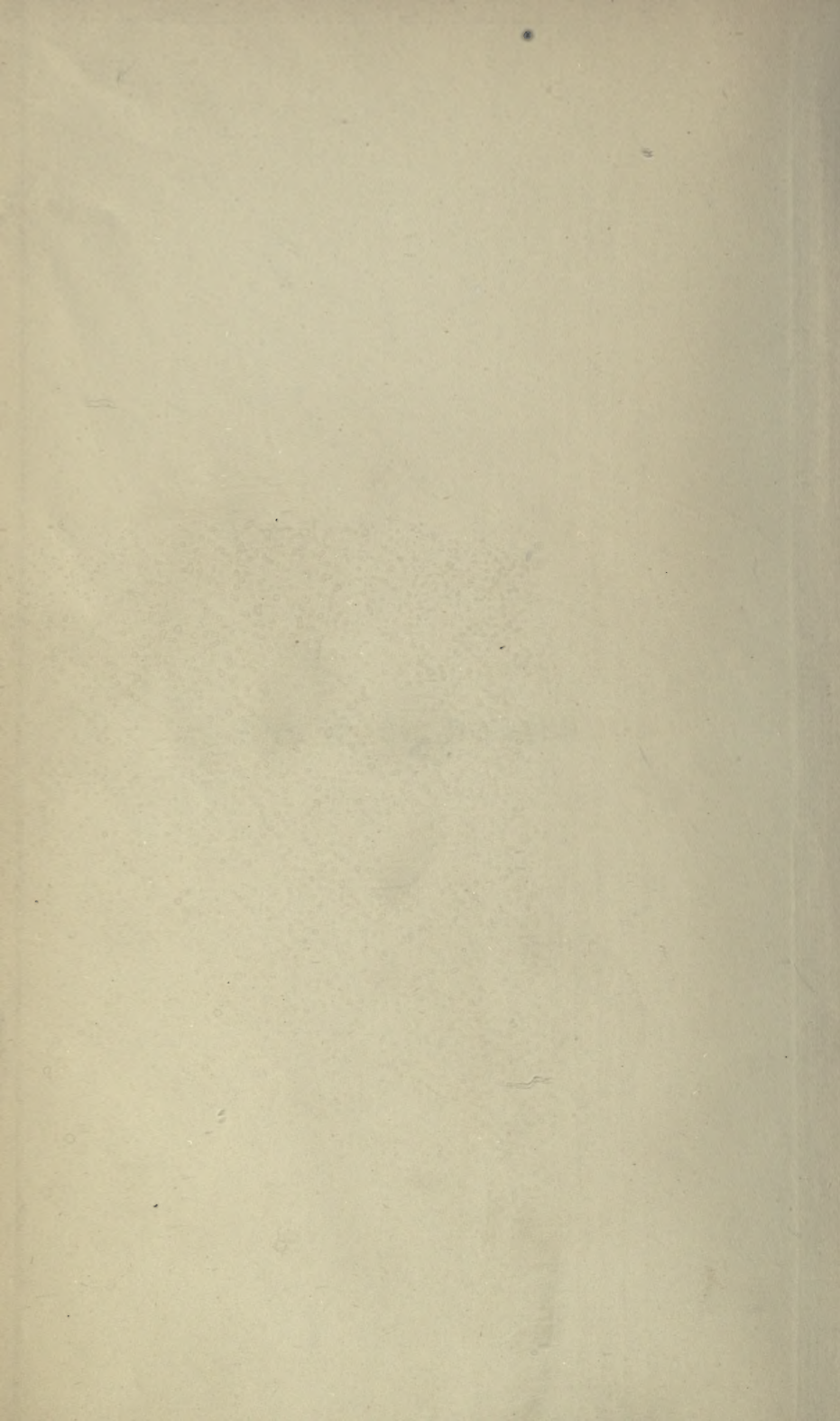


Dr. R. B. Nevitt





ARCHIVES OF SURGERY.

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ARCHIVES OF SURGERY.

BY

JONATHAN HUTCHINSON, LL.D., F.R.S.,

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Royal College of Surgeons.*

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NOTE.—The reader is requested to observe that the Plates do not always bear consecutive numbers. They have been printed for a smaller Atlas of Clinical Illustrations of Disease, which will be published on completion of the Archives, and their numbers refer to their proposed position in that work.

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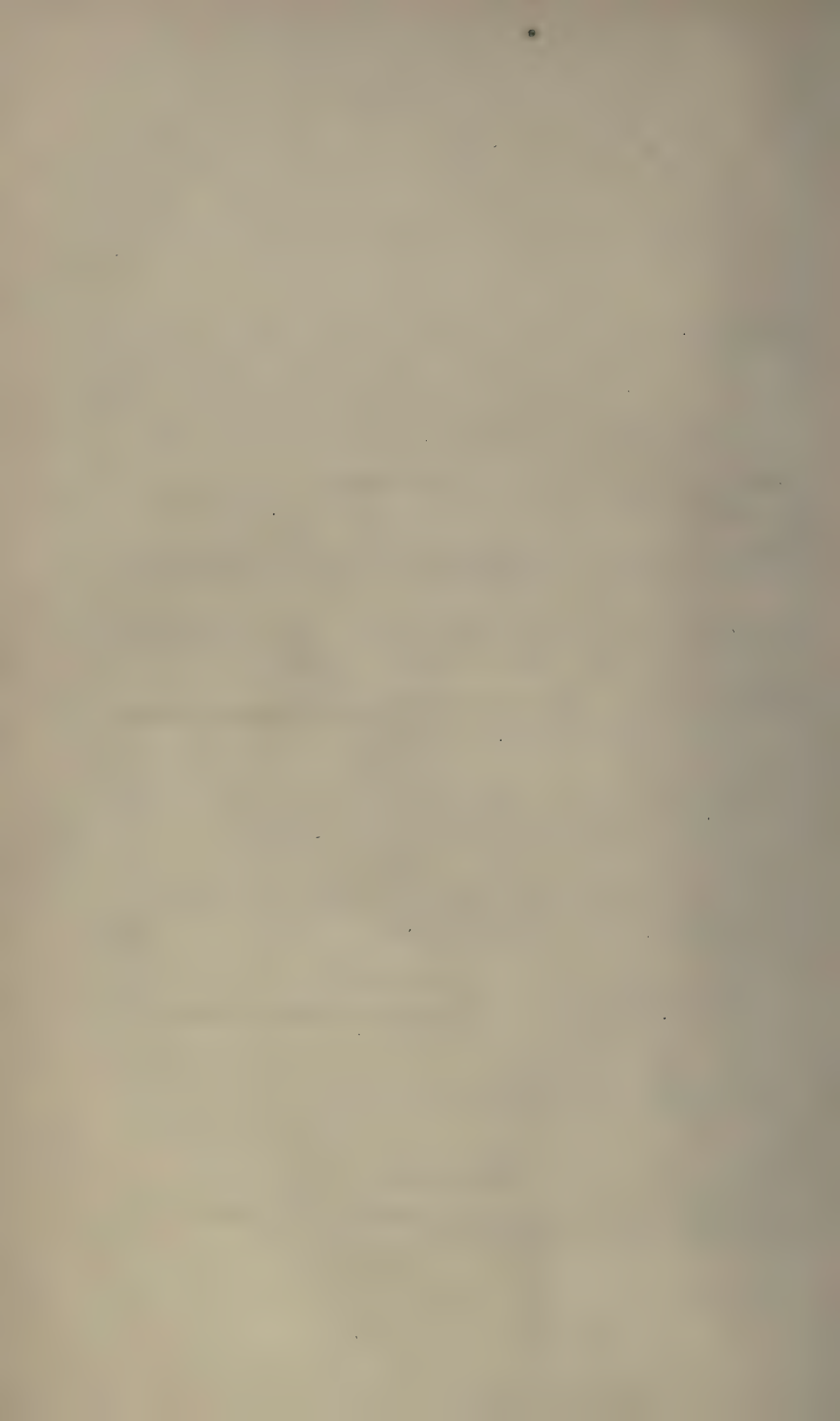
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ARCHIVES OF SURGERY.

JULY, 1890.

RECORDS OF INTESTINAL OBSTRUCTION, WITH ESPECIAL REFERENCE TO SYMPTOMS AND TREATMENT.

(Continued from page 256, Vol. I.)

WE are concerned with the passage of gall-stones in two quite distinct aspects. In the first place, a stone impacted in the common duct may cause pain, sickness, and constipation, and thus simulate obstruction; and in the second, a large stone may plug the intestine and thus become a cause of it.

The first-named group has, I feel sure, not received the attention that it demands. Attacks of bile-stone colic are constantly mistaken for other conditions, and they are far more common than is generally supposed. The symptoms vary very much in different cases, and they often exceed, both in severity, suddenness, and duration, all that seems probable. It has happened to me on many occasions to be called to urgent cases supposed to be abdominal obstruction, in which the diagnosis appeared to me to be bile-stone colic, and in which the subsequent progress confirmed that impression. It is a mistake to believe that the patient is usually able in such cases to locate the pain correctly, and it is a mistake to expect jaundice as an early symptom. It is further an error not to recognize that the severe pain present in these cases may induce a seemingly obstinate constipation. The reflex disturbances as regards vomiting and constipation are, indeed, not to be easily distinguished from those of mechanical

obstruction. In these cases the stone which causes the attack is often not a large one, and it may easily escape recognition in the stool. It is quite possible that in some cases in which it was lodged in the cystic duct it may slip back again. I cannot make the statement that in any large number of the cases to which I have just referred, I have actually proved the presence of a stone, but the sudden subsidence of the pain and the satisfactory recovery of the patient have often seemed to leave but little room for doubt.

To turn to the class of cases in which real obstruction is present, we may ask the question : Is it possible to make the diagnosis of a case in which the small intestine is plugged by a gall-stone ? I maintain that it is not practicable to get further than a mere conjecture. If the case is recent it will count as one of acute intestinal obstruction, and a band or a twist, or some other form of internal strangulation, will be suspected. Such has, I believe, actually been the diagnosis in almost every case in which the abdomen has been opened and a gall-stone found. In particular I may ask attention to one in which the operator was Mr. Bryant, than whom a more careful or experienced diagnostician could not be named. Mr. Bryant states candidly that he had before the operation taken the case to be one of "acute intestinal obstruction due either to a band, twist, or internal hernia."

A differential diagnosis is simply impossible, for the symptoms are the same. There is little to help us excepting the history of an early stage of symptoms referable to the region of the gall-bladder, and this is in many cases—I think in the majority—wholly wanting.

If the duration of the case have been longer, and it have passed into one of chronic obstruction, we still have nothing excepting the history by which to distinguish it from cases due to other causes. Cases of block by hardened fæces and by malignant stricture may each in turn resemble it.

When a gall-stone plugs the intestine it is fixed in most cases in the lower part of the ileum, not far from the cæcum. If it have once passed the valve and gained the colon there is no longer any obstruction, and its passage per anum will

probably soon be accomplished. A point, therefore, in the diagnosis of chronic cases from malignant stricture of the lower bowel is easily made in the fact that colon-distension is absent. Colotomy, which is the suitable resource in the latter, is of course useless in gall-stone plugging. Admitting, then, that a conjectural diagnosis (resting on the history) is in a few cases possible, it may be convenient to discuss the question of treatment under three different heads.

1st.—In a case of acute obstruction where the history points to gall-stone, what ought to be done? We will suppose that the patient's symptoms, the pain, sickness, &c., are urgent. I ask attention first to the fact that—in strong contrast with the dangers of strangulation by band, &c.—there is no risk of gangrene of bowel. The case, although it may appear urgent, is not really so. After all it is only one of block, and will pass into a chronic stage if let alone. It is not one in which speedy death is the only alternative to immediate relief. The probability is very great that even if no artificial aid whatever is employed, the stone will eventually pass. Foreign bodies far larger than gall-stones ever are, and presenting irregularities in their surfaces far more likely to cause difficulty, have in innumerable instances safely traversed the whole course of the intestinal tract. As regards gall-stones themselves, much larger ones have passed than any that have been found by the surgeon in laparotomy operations. Very few indeed are the cases in which at a post-mortem a gall-stone has been found in the small intestine as the cause of death. I have given in the appended plate some outlines of gall-stones in order to illustrate their size in reference to the possibility of their passage. Briefly it may be said that in no case is the stone so large but that its passage is both possible and probable. In Fig. 3 the stone was safely voided. In Fig. 1 the surgeon removed it by laparotomy, and the patient died eight hours after the operation. It will be seen that the stone is not really larger than others which safely passed, and the inference is that if patience had been exercised it might in this case also, without much real danger to life, have eventually come away.

Dr. J. W. Moore, of Dublin, records the case of an elderly woman who safely voided two large calculi after attacks characterized by agonizing pain, only slight jaundice, obstinate and incessant vomiting, and intractable constipation. The largest of these measured two inches and three-quarters in its shortest circumference.

In a second case recorded by Dr. Moore from the practice of Surgeon-Major Hare, of Mooltan, a lady of 43 voided stones on three occasions, after periods of four days' terrible suffering in each instance. The largest of these, which was nearly round, measured two inches in circumference.

In a third case by Dr. Moore, a woman of 47 voided seven large calculi after constipation with violent pain, but without vomiting. The largest weighed more than half an ounce, and had a smaller circumference of nearly two inches.

As regards the measures of treatment to be adopted in case of acute obstruction supposed to be due to gall-stone, I have no hesitation in recommending a combination of opium, anæsthetics, and injections. The condition is one of spasm of the muscular coats of the bowel caused by a foreign body. Excepting for spasm, there is no mechanical reason why the stone should not pass. To allay spasm, then, is our object. This may be done first by full doses of opium, and after these by the use of anæsthetics. Patients under the influence of opium bear chloroform well, and the latter should be used during long periods. No conditions are so likely to favour the slipping onwards of a stone as a prolonged state of full anæsthesia. During it the surgeon will of course take advantage of the relaxation of the abdominal wall to make careful manipulation with a view to diagnosis. He may perhaps be able to feel the stone. He will also freely distend the lower bowel alternately with water and with air. In time, one or the other or both may pass the ileo-cæcal valve, and if distension of the gut immediately below the stone can be accomplished, the latter is almost certain to slip onwards. It may even be desirable with this hope in prospect to inject with olive oil. Or the introduction of olive oil into the stomach in large quantities may be suitably tried.

If after an examination of this kind no relief is obtained, and no definite gain as to diagnosis obtained, it may then, the symptoms being urgent, be quite right to do an explorative laparotomy. There is, indeed, no alternative between this and waiting, and the decision will depend upon the surgeon's individual estimate of the relative dangers of the two. The case is at any rate definitely placed in the category of acute obstruction from unknown cause. As I have supposed that it has been ascertained that no part of the colon is distended by fæces, and that the whole of it receives the injection, it is clear that the cause is placed in the small intestine, and colotomy out of the question.

Let us next ask what ought to be done if a gall-stone in the small intestine have been felt with reasonable certainty. My reply must be unequivocal, I would wait. There is far less danger in trusting to the spontaneous escape of the stone than in attempting its removal by laparotomy. I will go even further than this, and say that if after the surgeon has opened the abdomen and found an impacted gall-stone, I doubt whether he will always do wisely to at once incise the bowel and take it out. I should first try very patiently to squeeze it onwards, should try by injections whether it could not be reached from below, and only as a last expedient allow myself to be tempted to open the gut. The few cases in which the operation has been completed have not given very favourable results. It is not an operation which can possibly be done without some danger of its own.

We have lastly to consider what ought to be done in cases of chronic obstruction which are possibly or probably due to gall-stone plugging. As already stated, emptiness of the ascending and transverse colon is the symptom which will chiefly distinguish these from fæcal blocks with or without organic stricture. Inasmuch as the smaller bowel is involved, the symptoms are likely to be less chronic and somewhat more severe than in the common run of the latter cases. As already repeatedly stated, colotomy, the ordinary resort in these, is here out of the question. The choice rests between a policy of waiting, with use of opium, belladonna, and injections, and an operation (enterotomy or exploration).

My own preference would be for the latter. I have known many cases in which, after prolonged symptoms and considerable suffering, a stone has been eventually voided, and the patient has recovered. In not a few which were, I suspect, of this nature, the stone was never found. In some cases, especially in elderly persons with distended and torpid large intestines, the stone may cease to obstruct and yet remain behind. This was probably the case in an old gentleman whom I attended many years ago with severe symptoms of obstruction. We gave chloroform, and practised the usual manipulations with free and repeated injections, and he was relieved. His bowels acted, and he recovered tolerable health. He had a year later a similar but not so severe an attack, which was relieved by like measures. Finally, six months later still he voided an enormous gall-stone.

As an example of one not uncommon class in which gall-stone plugging may be suspected, and in which the diagnosis is never made certain, I will quote the following. It is one in which an exploratory operation would certainly have been deemed desirable by those who advocate that measure.

CASE I.—Five days' obstruction with urgent symptoms. Gall-stone suspected. Abdominal taxis under an anæsthetic without obvious result, but followed after a short time by complete relief.

I saw Dr. W—— on Thursday, March 14, 1889, and met Dr. B—— and Mr. L—— in consultation at his bedside. It was the fifth day of his illness, and during the whole of this time, in spite of various treatment, obstipation had been complete. Our patient being a medical man himself, he was able to supply us with a very clear history of his symptoms. He said that he had been in his usual good health until the Sunday preceding my visit (on Thursday). He was accustomed to a daily action of his bowels, and but seldom used aperient medicine. On Friday, however, without any very definite reason, he had taken an aperient pill. This dose acted well on the Saturday morning. On Saturday

night, contrary to his custom, he took a hearty supper. He had some ill-defined abdominal discomfort during the night, and thought that his supper had disagreed with him. On Sunday morning he did not feel well, but got up and went out to see his patients. Whilst walking in the street, he was seized with sickness and obliged to vomit. He came home, found himself quite unable to eat his dinner, and during the afternoon had increasing abdominal discomfort. In the course of the evening it amounted to very severe pain, and he had repeated vomiting. He himself referred to the region of the cæcum as the part where from first to last the pain had been felt. He did not think that he had had any pain over the gall-bladder; but Dr. B——, who had examined his abdomen on the first day, said that there was then distinct tenderness over that region. When asked to describe the exact character of the pain, he said that he could not do more than say that it was very severe, fixed in one place, and easily increased by any movement of the body. He was obliged to carefully accommodate his position and to keep as still as possible. On the Sunday afternoon, when Dr. B—— first saw him, this severe pain, with some vomiting, was the chief symptom, and for its relief hypodermic injections of morphia were used. During the five days which had intervened before I saw him the treatment had been chiefly by belladonna. The pain had been constantly present, but much less severe than at first. There had been nausea throughout, but not much active vomiting. At no time had there been any increase of temperature. Enemata had been freely used, but nothing in the shape of fæces had been brought away; nor, with one slight exception on the afternoon of my visit, had there been any escape of flatus.

Dr. W——'s condition at the time of my visit was as follows:—His tongue was thickly coated, but not dry, and his countenance was anxious and expressive of much discomfort. His abdomen, which was rather fat and large, was not in the least tense, and he allowed me to handle it freely in all directions excepting over the cæcum. In this position he always complained of tenderness when I touched him. I thought I could detect an ill-defined swelling about the size

of a child's fist midway between the anterior spine of the ileum and the linea alba, and it was just over this part that he flinched when touched. The case seemed to me to be one of plugged intestine rather than of strangulation by band. The symptoms had not been so acute, nor had they shown such tendency to increase, as would probably have been the case in the latter. The absence prior to this illness of any tendency to constipation, or of attacks of pain, were facts opposed to the suggestion of malignant stricture. I suggested to him that he might be suffering from a gall-stone impacted in the bowel, to which he at once replied that he had not been a bilious subject, and that he had had no symptoms of the escape of a gall-stone from the gall-bladder. He had no jaundice during the present attack, and had indeed never had anything definite of that kind. He said, however, that he had repeatedly been a little yellow.

Knowing well how frequently all history of bilious attacks is absent in cases of large gall-stones, I did not attach much importance to the negative facts in this instance. It appeared very possible that the early symptoms (severe pain and sickness) might have been those of the passage of the stone from the gall-bladder. The pain was described as having been most acute at that time, and after a while there had come a lull with obstipation only. On the whole, I thought the diagnosis of gall-stone the most probable.

The sequel to this narrative may be very briefly given. Having made adequate preparations as regards assistants, I had my patient (a friend and colleague) placed under chloroform, and then, during more than half an hour, practised the various details of abdominal taxis in full completion. We obtained neither *faeces* nor *flatus*, nor was I able to add anything to the facts aiding our diagnosis, excepting that the colon received the injection in very large quantity, and became visibly distended by it. The result was, however, that the bowels acted within a few hours of my leaving the house, and that a satisfactory recovery followed. No gall-stone ever appeared. This is more than a year ago, and my friend remains well.

In the above case, and in some others recently, I used for

PLATE LVII.

ILLUSTRATIONS OF THE SIZE AND SHAPE OF GALL-STONES.

FIG. 1.—The stone removed by Mr. Bryant in the case quoted at page 10. It measured more than three inches in circumference. It was removed by a laparotomy operation.

FIG. 2.—A stone, which was removed by Mr. Bryant from the gall-bladder of a woman, aged 53. A sinus existed; the concretion could be felt by a probe. The sinus was enlarged, the stone extracted, and the patient made a good recovery (see 'Transactions of the Clinical Society,' vol. xii. p. 20). No jaundice or symptoms of biliary disease had ever occurred.

FIG. 3.—A stone, which was passed per anum by a woman, aged 53, after five days' symptoms of obstruction. The obstruction had been supposed to be due to an umbilical hernia, from which she suffered. She had never in her life had jaundice, nor had there been any attack indicative of the escape of the stone from the gall-bladder to the intestine. The stone had a largest circumference of more than three inches. It was of light sp. gr., but weighed 228 grains. (See 'Medico-Chirurgical Transactions,' vol. vi.)

FIGS. 4, 5, & 6.—Are given to illustrate a fatal case of chronic obstruction by gall-stones, and at the same time the great difficulties which attend diagnosis. The patient, a woman, aged 59, died of perforation of the ileum, just above the cæcum, eight months after the probable date of escape of the stones from the gall-bladder, and after eight weeks of incomplete obstruction. The symptoms had been vomiting, constipation, and severe griping pain, but they had been repeatedly relieved by treatment; the bowels had acted well, and at no time, until the last few days, had there been abdominal distention. There had never been jaundice, and the patient had usually enjoyed fair health. Eight months before her death she had passed through an attack of constipation, with great pain, and

PLATE LVII.—*continued.*

at that time a hard tumour could be felt in the right hypochondrium. At the autopsy the gall-bladder was healthy, and no conditions were found which threw any light upon the mode by which the stones had escaped. Each of the larger stones measured about four inches in circumference. There was no proof that any accretion had been received from the contents of the intestine.

It will be seen that in this case no permanent obstruction was caused, and that for months together the bowels acted well. Death was not from obstruction, but from perforation from irritation. The fact that there were several stones, and some small, probably conduced to this result.

The case is recorded, by Mr. Le Gros Clark, in the Medico-Chirurgical Society's 'Transactions.' It is republished in full, with other important illustrations of gall-stones, in the 'Pathological Atlas of the New Sydenham Society' (Fascic. VII.), a work which ought to be in the hands of all.

I am acquainted with the particulars of a case in which a lady, after a very prolonged and repeatedly almost fatal illness, voided a calculus as large as the largest of those here shown, and recovered.

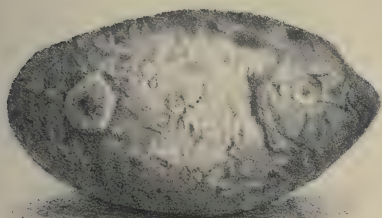


Fig. 1.

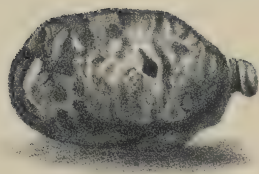


Fig. 2.

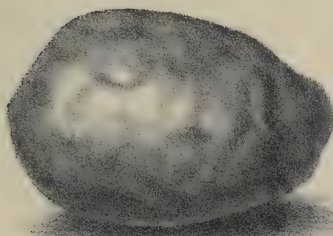


Fig. 3.

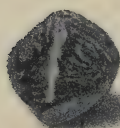


Fig. 4.

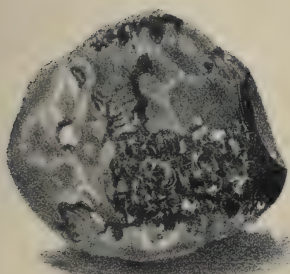


Fig. 5.



Fig. 6.

Gall Stones.

(Copied from various sources to show form & size.)

West, Newman, lith.



injection purposes hydrostatic pressure with a glass tube so inserted, that I could easily see for myself how much pressure was being exerted. The funnel, which was held about eight feet high, was inserted into a large indiarubber tube, and the tube which passed into the bowel was also rubber, but between was two feet of a large bore tube of glass in which the rise or fall of the fluid could be observed. We injected the intestine till the abdomen was as tight as a drum, and kept it so for some minutes at a time. The fluid during these periods of waiting was allowed to sink until the top of the column was visible in the glass tube. By this expedient I made sure that the pressure was adequate, and yet not such as to risk rupture of the bowel. The slightest touch of the hand on the patient's abdomen at once caused the column to rise in the tube, proving, I should suppose, that the pressure was as much as could be suitably employed. The anus was kept closed by the fingers. This might conveniently have been done by a Lund's plug, but the fingers were quite efficient.

With this case we may suitably contrast the two following, in both of which the presence of a gall-stone and of intestinal plugging was made certain. In the first I ask particular attention to the circumstance that there was no history of biliary disorder before the attack. The patient had never had any ailments whatever, and the symptoms set in with such sudden severity that the diagnosis made was that of strangulation by a band. It will be seen that on the fourth day of the illness the symptoms in the two cases were remarkably alike, and the degree of urgency, so far as we can appreciate it from the records, much the same. On this day in the one case the operation was performed, whilst in the other it was not.

CASE II.—*A Gall-stone Case. Acute symptoms supposed to be those of obstruction by a band. Laparotomy—Removal of the Calculus—Death. (Clinical Society's Transactions, vol. xii. p. 106.)*

Mrs. R——, æt. 50. Never any illness whatever before.

DATE.	DAY OF ILLNESS.	DETAILS.
Aug. 5	1	Woke in the night with sickness and severe abdominal pain. Vomiting and pain.
„ 6	2	Vomiting and pain; opium given, but rejected.
„ 7	3	
„ 8	4	Seen in the evening by Mr. Bryant. In great pain; much fæcal vomiting; abdomen distended, tender, and tympanitic. No peristalsis. Centre of pain to left of navel.

At this date the patient was removed to Guy's Hospital for operation. A gall-stone was excised from bowel: gut closed by catgut suture. Intestine above punctured at two or three places to give exit to flatus and fluid fæces. Death eight hours after the operation. Acute peritonitis; no fæcal extravasation. The gall-stone had travelled to within a foot of the cæcum. The stone had a circumference of $3\frac{1}{2}$ inches. (See Fig. I. in Plate.) The stone had probably passed by ulceration from gall-bladder to duodenum. It was a long oval, and weighed 238 grains.

The diagnosis made before the operation was that of "acute intestinal obstruction, which was supposed to be due either to a band twist or internal hernia."

CRITICISM.—*The calculus had taken four days to traverse the length of the small intestine, and was within twelve inches of the cæcum. Had it been let alone a few days longer, it is not impossible that it might have dropped safely into the cæcum and all danger would then have been passed. It must be admitted, however, that it was of very large size.*

Both in this and the following case the vomited matters are described as having been "fæcal" and "stercoraceous." It is almost certain that they could not have come from the large intestine, since the bowel was plugged; and further, inasmuch as the plug had travelled downwards from the duodenum, it had probably made impossible the regurgitation of anything swallowed before the beginning of the attack.

CASE III.—*Case in which a large Gall-stone was passed after twelve days' obstruction. Recovery. (Clinical Society's Transactions, vol. vi. p. 194. Dr. J. S. Gray's case.)*

DATE.	DAY OF ILLNESS.	DETAILS.
Dec. 14	1	A man aged 40 was seized with nausea, pain, and vomiting. Pain paroxysmal and referred to navel.
„ 15	2	Seen by Dr. J. S. Gray, the narrator. Pain very violent, vomiting distressing, and matters ejected very offensive.
„ 16	3	Less pain and all the symptoms better, but no action of bowels. He got up and went out.
„ 17	4	Much worse in all respects; vomit stercoraceous; countenance haggard; desponding as to the result; an enema brought away fæces. This was the last motion until 24th.
„ 18	5	The sickness still urgent. Probably the enema had only cleared the bowel below the obstruction.
„ 19	6	Fed by enemata; vomiting and constipation.
„ 20	7	The same.
„ 21	8	The same.
„ 22	9	The same, but less urgent.
„ 23	10	The same.
„ 24	11	The bowels acted spontaneously and freely. The vomiting ceased, and in the course of the evening a large gall-stone escaped.

The stone weighed an ounce and 13 grains, and its smallest circumference was more than two inches.

CRITICISM.—*Here we have an attack of twelve days with obstipation and stercoraceous vomiting the whole time, with the exception that once an enema brought away fæces. On the fourth day the symptoms would have well justified an abdominal exploration (compare with preceding case).*

BULLET WOUNDS OF THE ABDOMEN.

(TWO CASES.)

CASE I.—*Bullet wound of Abdomen (Suicidal)—Survival for five days—Absence of the usual symptoms of peritonitis—Perforation of liver, pancreas and kidney.*

I ATTENDED the following case some years ago in consultation with Dr. Hill, of Mecklenburg Square.

An old gentleman of 78, who was in much pecuniary trouble and had once or twice before attempted suicide, finally shot himself in the abdomen with a revolver. He was sitting in a chair at the time, and it appeared that he had lifted up his shirt but not his vest. The ball had entered to the left of the middle line in the upper part of the epigastrium, and was lodged in the soft parts near the tip of the left 12th rib. There was much ecchymosis in the latter position, and a hard substance could be distinctly felt beneath the bruise. I cut down upon it and easily removed the bullet.

The injury had been inflicted at 3 in the morning of a Monday. He was found at 7, in collapse, and almost pulseless. The usual remedies were employed, and when I saw him at 3 o'clock in the afternoon he had much rallied. He was a thin, wiry man of an iron constitution. During the first twelve hours after the accident he repeatedly vomited, and invariably did so after taking anything to drink. The matters ejected were always stained with blood. On several occasions the urine also contained blood, but this was a symptom from which he had suffered several times before. No symptoms of peritonitis followed. The abdomen was almost free from tenderness, and did not during the first three days become distended. We inferred from the sickness and vomiting of blood,

together with the direction which the ball had taken, that the stomach had probably been wounded, although the absence of signs of peritonitis, and the fact that the collapse, instead of increasing, had passed off, seemed to point to an opposite conclusion. We consequently directed that he should be fed solely by enemata, and allowed him to take fluid by the mouth only in teaspoonfuls at a time. He resented this very much, and begged to be allowed to eat and drink.

From the Monday morning on which the accident happened to the Friday, he seemed to be doing well. The temperatures were never above normal, and there was nothing to indicate peritonitis. On the Friday morning he suddenly became alarmingly weak. I saw him on Friday afternoon at 6 o'clock, and then found the abdomen considerably distended. His pulse was very weak. He died on the Saturday morning, having lived a little more than five days.

At the post-mortem we found that there had been no direct injury to the stomach. The ball had passed through the left lobe of the liver, above the lesser curvature of the stomach, and through the pancreas and kidney. It had entered the latter at its hilus, and passed out by a large, ragged opening which would have admitted a finger near the middle of its greatest convexity. There was a good deal of extravasated blood about the viscera which had been wounded, and enough in the peritoneal cavity to thinly coat all the intestines. There were no indications of peritonitis.

It is to be remarked that though the visceral injuries were so severe, yet from the progress during the first four days it had appeared possible that the man would survive. It becomes a question whether it might not have been advisable to have yielded to his entreaties to give food by the mouth more freely. We had forbidden it because it caused him sickness, and from the belief that his stomach was wounded. Upon this latter point, however, some doubt had been expressed from the first on account of the absence of signs of peritonitis, and of extreme collapse. As to the source of the blood which was present in the vomit during the first twelve hours, we could only infer that it had been due to contusion of the stomach, as there was no perforation.

CASE II.—*Bullet wound of Abdomen—Severe symptoms of diffuse peritonitis—Proposed exploration.*

About the same time that I attended the patient whose case is the subject of the preceding note, I saw another which may suitably be placed by its side. I was called late one night to a consultation of the whole surgical staff of the Poplar Hospital, in the case of a ship's captain who had been shot in the abdomen. An American passenger on board the vessel had at the end of his voyage, wishing to unload a pistol, discharged it upwards out of the cabin window. The captain chanced to be walking above, and received the bullet in his abdomen under the navel. There was no clue to the present position of the bullet. It was the third or fourth day after the accident, and all the signs of general peritonitis were present.

When I got to the hospital I found that all preparations had been made for opening the abdomen to search for the bullet. The abdomen was tense, tender, greatly distended, and the symptoms were very urgent. I represented to my colleagues, and particularly to Mr. Brownfield, whose patient the man was, that although it might perhaps be good surgery to explore, yet that the man's condition was such that he might very likely die on the table, and that with such distension as was present it would be very difficult to return the intestines. It seemed probable that some important viscus was wounded, and but little likely that the operator would find it possible to repair the damage. We finally arrived at the conclusion (a rather cowardly one, possibly) not to interfere. My own belief was that the man would not live through the night under any circumstances, and that if his abdomen were once opened he would not live to have it closed again. We continued the treatment by hot poultices and opium which had been previously used.

To my great astonishment I heard from my friend Mr. Brownfield, some weeks later, that this patient had recovered. From the date of the consultation he had begun to improve, and he had since left the hospital quite well, still carrying the bullet with him. I hesitate to quote this case for imitation, or to defend the negative measures for which I was responsible. It is desirable, however, that such facts should not be wholly forgotten.

ON BALANITIS AND ALLIED AFFECTIONS.

No. I.—*A Plea for Circumcision.*

It is surely not needful to seek any recondite motive for the origin of the practice of circumcision. No one who has seen the superior cleanliness of a Hebrew penis can have avoided a very strong impression in favour of the removal of the fore-skin. It constitutes a harbour for filth, and is a constant source of irritation. It conduces to masturbation and adds to the difficulties of sexual continence. It increases the risk of syphilis in early life, and of cancer in the aged. I have never seen cancer of the penis in a Jew, and chancres are rare.

No. II.—*Syphilitic Lupoid affection of the Glans Penis.*

There is an exceedingly troublesome affection of the glans penis which occasionally follows some years after syphilis, and which is, I think, an analogue of lupus. It consists in the development of yellowish-brown spots, which coalesce into patches and spread at their edges. Sometimes they ulcerate and form crusts, but I have never had any trouble with cases in that condition. They always heal quickly under syphilitic treatment and the use of an iodoform ointment. When, however, the patches are perfectly quiet and show only a little thickening and yellow-brown discoloration, then I have found the condition very difficult to influence by either local or internal remedies. In this it much resembles the more chronic forms of psoriasis palmaris as we see them after syphilis.

Two examples of the condition referred to above have impressed themselves upon my memory, and are perhaps worthy of mention as examples of it. The first is that of a married

surgeon who had syphilis many years ago. When he came under my treatment he had for long been perfectly well, with the exception of some yellow-brown lupoid patches, which covered the greater part of his glans and caused him great annoyance. They had once or twice inflamed a little, but for the most part were quite quiet. This gentleman took specifics in varied forms and in full doses during nearly a year. We rubbed in iodoform ointments, oleate of mercury, and mercurial ointments of various composition during most of this time. He submitted, also, on two occasions to a liberal cauterization of the part with the acid nitrate of mercury. We got the disease very much better, but as may be inferred from the length and variety of the treatment, we did not easily or completely cure it. His general health throughout was very good, and he had no other syphilitic manifestations. Although I believe he is now nearly if not quite well, I dare not, with confidence, record a cure.

My second case is that of Count N——, a gentleman of dark complexion and in excellent health.

He came under my care first in 1875, and then suffered from a tuberculo-lupoid eruption on the scalp and on one forearm. He had been treated in Paris three years previously for a "chancre mou," which had left a large and deep scar in the glans penis. I have seen Count N—— on and off from 1875, but during several years of that period he has resided abroad, and his treatment has been much interrupted. He is an excellent patient, but apparently enjoys such vigour of constitution that drugs produce but little effect on him. He has taken at different times large quantities of mercury in various combinations, and with and without iodides. Nothing ever disagrees with him, and he has never had his gums in the least touched. He has not suffered from syphilis on any other part than the skin and glans penis, and on these parts it has always taken the form of a tuberculo-lupoid eruption. This has often been cured for a time, but has shown a remarkable tendency to relapse when the specific treatment has been suspended. My reason for mentioning his case in the present connexion is because the condition referred to affected at one time his glans penis, and proved remarkably obstinate. The

corona and a considerable part of the glans showed smooth brown papules which became confluent into patches of considerable size, and persisted, in spite of all remedies from month to month, for more than a year. As in the preceding case, I cauterized them repeatedly, and we used also iodoform and mercurial ointments with great perseverance. At the present time Count N—— is quite well as regards his penis, and also his syphilitic affection of the skin; but he has recently consulted me for a general eruption on the trunk and limbs which resembles a modified form of lichen planus. It is yielding to chrysophanic acid and arsenic, and I do not think that it is in close connexion with syphilis.

I have seen many other examples of syphilitic lupoid affections of the glans penis, and have generally found the disease far more difficult of cure on that part than on the skin itself. The two which I have quoted are, however, by far the most intractable examples of the condition which I have ever met with.

No. III.—*Common Lupus affecting the Prepuce, and rendering Circumcision necessary.*

It is generally acknowledged that common lupus but rarely affects the genitals in either sex. It is, indeed, a disease which is chiefly seen on parts exposed to the influence of changes in temperature, and is rarely seen on parts which are constantly kept warm by the clothes. It might almost be said never to begin in the latter parts. I have recently performed circumcision in order to rid the patient of a prepuce which was affected by lupus, but it is almost the only case in which I ever remember to have witnessed such a condition. The case was a very remarkable one, and has already been in part recorded in my lectures on lupus.* The patient was a young boy in whom lupus developed itself as an acute inflammatory eruption in large patches over various parts of the face, limbs, and body. In the end the patches assumed unmistakable conditions of the form of lupus known as non-ulcerating, and as such the disease, at the end now of four years, still persists.

* See *British Medical Journal*.

Amongst the parts attacked were the lobule of the right ear and the prepuce. The latter was long become much enlarged by the lupus growth. I was able to remove the whole of the latter by an ordinary circumcision, and the parts healed well and have remained sound. The explanation of the affection of the genitals in this case is no doubt to be found in the extraordinary vigour of infective activity which the disease showed in the first stage, aided probably by the youth of the patient.

BALANITIS PERSTANS.

There is a very peculiar affection of the glans penis of which I have seen a few examples, but which, so far as I know, has never been described. From its chronic, indeed almost incurable, character, the name which I have suggested seems applicable. It occurs, I think, only in men past middle age. The glans shows abruptly-margined map-like areas of a deep red colour and slightly moist, but not raised nor in any degree ulcerated. They remain for years together, with no change excepting slow extension. The surfaces affected look slimy and glazed, and easily crinkle like tissue paper.

No. IV.—*An example of Balanitis Perstans.*

A gentleman aged 45, who was sent to me by Dr. Hughlings Jackson, afforded a good example of this condition. He was unmarried, and there was nothing special in the state of his health. Retraction of his prepuce disclosed almost the whole glans apparently in a state of acute superficial inflammation, red and shining as if covered with moisture or with vaseline. Yet it was scarcely moist, and no secretion could be removed, nor were the appearances materially altered by wiping. On careful inspection it was seen that the red patch included the greater part of the glans, but was everywhere abruptly margined. Its edge was more congested than the surface. However much wiped, the surface always remained bright and glistening. The corona glandis was nowhere involved in the edge of the patch coating close to it. The opposed surface of the prepuce was in a

precisely similar condition. The parts looked as if very irritable, but he declared that there was no itching whatever, and no soreness. If, however, the part were rubbed roughly, a peculiar aching was produced. He said that the condition had been present for seven years, and persisted, or rather extended, in spite of the utmost cleanliness. He always washed night and morning. It gave him no inconvenience, and were it not for the look of the thing, and that it soiled his linen, he would not care anything about it. There was a rim of congested blood-vessels around the meatus, but no soreness. He did not recollect having suffered from balanitis as a schoolboy.

The state described above was exactly like that in another gentleman of past middle age, who was sent to me by Dr. Fenwick. He was married, and of most cleanly habits. His patches in the glans were abruptly mapped out and always the same, red, glossy, and crinkly. He came to me at intervals for more than a year, but I failed to cure him.

NOTES ON SMALL-POX, VACCINATION, AND EXANTHEMS.

No. I.—*Insusceptibility to Vaccination.*

SINCE my former note on this subject I have received the following letter from a medical friend. The explanation which I would suggest is that he had in reality been exposed to small-pox in infancy, and had the fever without the eruption.

MY DEAR SIR,—On reading your estimable ARCHIVES I thought I would send you particulars of my own case after reading your remarks in the January number, p. 223, on “Insusceptibility to Vaccination.”

I was a public vaccinator for over thirty years, but was never vaccinated in infancy; never had small-pox. It is a fact, however, that during my office I vaccinated myself over four hundred times in every conceivable part of my body where I could get at it with lymph direct from the arm, but *unsuccessfully*. About the third or fifth day it seemed certain I was caught, but only to be disappointed, and in seven or eight days all would be dried up into a scab. I may add I have attended hundreds of small-pox cases. I was also invulnerable to the operation by friends who asked “to try their strength.”

Yours faithfully,

D. J—, M.D.

No. II.—*Variola sine Variolis. The doctrine of abortive exanthems.*

Concerning the occurrence of a protective small-pox without an eruption, Boerhave writes (Aphorism 1399): “You’ll often find a small-pox fever without any small-pox at all breaking out.” His translator adds, “And the patient in all probability never be in danger afterwards of having them more than any other that has had ’em break out effectually.” Both author and commentator agree in believing that the appearance of the eruption may now and then be prevented

by treatment, a statement which may be held to imply that they had both witnessed special examples of variola sine variolis.

No. III.—*Mortality from Chicken-pox.*

A certain number of deaths from chicken-pox are every year registered in Ireland. In 1864 there were 12, in 1870 only 2, in 1883, 13, and in 1888, 5. In answer to the suggestion that most of these were modified small-pox is the fact that the number recorded in the several years bears no proportion to the prevalence of small-pox. Thus in the year 1883, in which no fewer than 13 were registered as deaths from chicken-pox, the small-pox mortality was only 29; whilst in 1872, when the latter was 3,248, only 5 deaths from chicken-pox were registered. In 1884 chicken-pox produced almost as large a mortality as small-pox, the numbers being 4 of the latter and 3 of the former. The great variability of the number of deaths from chicken-pox in different years would suggest that severe epidemics had at times prevailed; thus it was 2 only in 1868.

No. IV.—*Rashes resembling Scarlet Fever.*

Dr. Cotman reported to the Hunterian Society in November, 1888, two cases in which adult men were the patients. In each, two attacks had occurred. The rash in one was preceded by symptoms of cold-catching, for which a "diaphoretic" was taken. In the other, severe neuralgia in the forehead preceded the eruption. The rash in each resembled scarlet fever, and was universal. In both universal desquamation followed the eruption, even the hands and feet peeling, and in one attack the nails falling. In neither case was the patient seriously ill. I had a case in which a similar history was given.

No. V.—*Vaccination during Secondary Syphilis.*

A gentleman comes to me who, during the prevalence of small-pox, was vaccinated whilst he had a secondary eruption of syphilis on him. He was taking mercury at the time.

The syphilis proved very severe, and the rash passed into rupia, and is still at the end of a year not quite well. His vaccination spots, too, both took well; they were long in healing, and have left two little dusky buttons of keloid.

No. VI.—*Keloid in Vaccination Scars.*

Mrs. T——'s infant, now eight months old, who was vaccinated five months ago, has now two little buttons of keloid, her vaccination scars. One of them is very definite, glossy and hard, the other less so. The scars are rather irregular. I am told that the vaccination went on quite well, and healed as soon as usual. She is brought to me on account of a suspicion of hereditary syphilis, and has eczema. I doubt as to the syphilis.

No. VII.—*Keloid in Vaccination Scars (another case).*

Dr. Watson, of Tufnell Park Road, has been kind enough to supply me with the following facts. I have since been favoured with an opportunity of seeing the child.

DEAR SIR,—Your statement in the last volume of ARCHIVES, that nothing is less common than for vaccination scars to take on keloid induration, must be my excuse for troubling you with the following notes:—T. L. æt. 1 $\frac{1}{2}$. Vaccinated at four months with calf lymph in three places, which all took. The mother, who is careful about her children, is sure that the vaccination did not run an unusually long course, and that there was no fœtor from the sores. She is sure it was all over in a month. The child was brought to me with three distinct keloid nodules in September, 1889. They had just been noticed.

T. L. is the third child. First died of diarrhoea, æt. 4 months; second of bronchitis, æt. 18 months. Neither first nor second was vaccinated. No miscarriages. No suspicion of syphilis has ever arisen in connection with the family since I attended them, *i.e.*, at the birth of T. L.

I have no doubt I could get the mother to bring the child in to see you if the case is of sufficient interest.

I am, yours very truly,

C. S. WATSON.

No. VIII.—*A case in which in a puny child good vaccination vesicles inflamed and ulcerated, and an eruption followed. Death in the sixth week.*

The particulars of the following case which occurred some years ago have been supplied to me by a medical friend. I never saw the patient.

1st week	Vaccination: patient a puny child a month old. Three others done at same time from same lymph did well.
2nd week	Vesicles looked so satisfactory that it was proposed to use them for arm to arm vaccination. This was, however, not done.
3rd week	The sores had ulcerated, and there were vesicles round their margins. Some spots appeared lower down the arm, and a few on the legs.
4th week	The eruption was not symmetrical, though it became fairly general in the limbs. Not on the body.
5th week	Notes imperfect. Vaccination sores presumably still unhealthy.
6th week	The child died apparently from exhaustion.

COMMENTS.—The above is probably a good example of a certain class of vaccination cases which go wrong. There is not the least reason to suspect any want of care in the vaccination or defect in the lymph. Nor is it probable that the child was the subject of inherited syphilis. There was from first to last no syphilis in the case. The child was simply puny and feeble, its vesicles after full development inflamed, and the products of inflammation proved infective, and produced vesicles, &c., first in close proximity with the part, and subsequently at a greater distance. This fact of local infection with satellite sores, and the non-symmetry, separate the case from one of ordinary vaccinia exanthem. In the latter the eruption is symmetrical, and is in no way associated with inflammation of the original vesicles. Nor do such cases end fatally, for the eruption is in its nature transitory. Cases of pus-contagion or infection by the products of inflammation, such as I suppose this to be, are indefinite in their duration; their severity depending much upon the state of health of the patient.

If we ask as to the cause of the inflammation of the vesicles

in the first instance, at the stage where they ought to have dried up, several hypotheses are open to us. They may have been subjected to mechanical irritation, their crusts rubbed off prematurely, and their surfaces exposed to atmospheric contagion. This is an exceedingly probable supposition, and the general carelessness as to the protection of arms during the healing stage is probably much to be regretted. Inflammatory action of a non-specific character once set going by any cause may probably become a source of infection to other parts, and in a certain sense of blood-poisoning. Nor is there anything extraordinary in the circumstance that puny, ill-cared-for infants die occasionally under illnesses of this kind. Another suggestion may be made as to the possible cause. The sores may have been infected by some non-specific secretion at the date of the visit at the vaccinator's surgery on the eighth day, when the vesicles were punctured and "wiped dry with a clean cloth." The absence of other similar cases in the same surgeon's practice makes, however, this supposition less probable.

ON MORPHŒA, DIFFUSE SCLERODERMA, AND ALLIED DISEASES.

Our knowledge of the diseases classed as Morphœa of Sclerodermia has greatly advanced of late years. The accumulation of clinical evidence respecting what twenty years ago ranked as little more than a curiosity, has been so considerable that we are now able to separate with some degree of clearness into several groups what were formerly classed as one malady. All our recent systematic works, Jamieson, Robinson, Crocker, Duhring, &c., contain well-written chapters upon them, in which the principal lines of separation are clearly marked. We now separate clearly the ivory patch localized invariably non-symmetrical morphœa from the diffuse and invariably symmetrical form. From both of these we distinguish the diffuse and general condition of œdema with hardness and coldness which is seen only in infants (Sclerema Neonatorum). There remain, however, many important questions upon which at present our knowledge is not sufficiently detailed. I have already written repeatedly, and at some length, upon this group of maladies, but as my last communication was now ten years ago,* and many facts have accumulated since, I now purpose to return to it. I shall begin by recording the notes of some cases, and in subsequent papers shall introduce general comments.

* See Atlas of New Sydenham Society and descriptive catalogue. See also "Lectures on Rare Diseases of the Skin."

CASE I.—*Diffuse Scleroderma preceded by Œdema, but exempting the hands—Face not much affected—Insomnia and remarkable loss of flesh—Great inconvenience from stiffening of legs and abdomen—Death from Erysipelas about a year from the beginning of the disease.*

Mr. H. E——, aged 53, a commercial traveller residing in L——, was brought to me by Dr. L—— of that city, in the early part of January, 1880. His first symptoms dated back one year, when he began to lose flesh and suffer from sleeplessness. He did not, however, seek advice till six months later, when he consulted Dr. L—— on account of swelling of his legs and inability to sleep. At this time his urine contained large quantities of phosphates, but no albumen. In September Mr. E—— went to Smedley's hydropathic establishment at Matlock. Here he remained two months, chiefly complaining of distressing insomnia and of the swelling of his legs. It was thought that there was some ascites. By the treatment a copious furuncular eruption was produced. He left Matlock much weaker, but almost free from œdema. Up to this time the peculiar stiffening of the skin had not attracted attention, having been, perhaps, to some extent concealed by the œdema.

When in January, 1880 (six months from the beginning of symptoms), Mr. E—— was brought to me, his condition was as follows: The skin almost universally stiff and board-like. The lower extremities were the worst, and certain parts, the scrotum and penis and the hands, were exempt, whilst the buttocks, the sides of the abdomen just above the iliac crests and the axillæ, were but slightly hardened. The hands from just above the wrists were quite free (exactly as in Mrs. B——'s case). There was no ascites, and not much œdema of legs. He was in fair health, but had lost two stones in weight during the last year (from $12\frac{1}{2}$ st. to $10\frac{1}{2}$ st.). His pupils acted well and his bodily functions seemed natural, with the exception that he still slept very badly. His sleeplessness was perhaps in part caused by

pain, soreness and stiffness in his legs. He said that his legs felt numb and shins sore, as if bruised. The middle parts of the face were less rigid than other regions. There were no ivory patches, but the cheeks, &c., showed tufts of dilated vessels (stigmata).

In this case no cause could be assigned. The gentleman had always lived regularly, and there had been no special exposure to cold. He thought he might have taken cold in July, but this was subsequent to the beginning of some of his symptoms. As in Mrs. B——'s case, loss of flesh steadily continuing had been a marked symptom.

I did not see this patient, excepting on the one occasion to which the above notes refer. About two months later, Feb. 22, 1880, Mr. L—— wrote to me that Mr. E—— was worse, and that he was suffering from almost total insomnia. He stated that the hide-bound condition had increased, especially about the knees and the lower part of the abdomen, "so that he cannot stand upright and has great difficulty in walking at all—getting upstairs being almost an impossibility." In May, Mr. L—— again wrote to me, "He is now in a most wretched state. The legs and thighs are flexed and abducted, and the skin of the abdomen and thighs is intensely hard, brawny, and tight. So is that of the arms. The face is not affected. His sleeplessness is still the most formidable feature. He has no rheumatic pains, but suffers along the attachments of the abdominal muscles from a dragging sensation. His bowels act well, appetite good, and mind quite clear." From this time, the poor fellow lived on for four months longer. He died of an attack of erysipelas in September, 1880. He was believed to have contracted it from sitting in a draught in his office. It spread from his legs to his trunk. In this respect the cause of death was the same as in the case of Mrs. B——, who died of erysipelas in the London Hospital. Mr. S——, of L——, was kind enough to send me details of the autopsy. Nothing was disclosed of any importance in reference to the morphœa. The kidneys were large, soft, and pale, the liver fatty and granular.

CASE II.—*Case of diffuse Morphœa or Scleroderma which was at first supposed to be caused by arsenical dust—Changes general but only slight—Hands and feet scarcely affected.*

In the case of Mrs. B——, of H——, those who first saw her were inclined to suspect that the disease might have begun in arsenical poisoning, but subsequently it became probable that this was a mistake. Mrs. B—— was a lady of about 26, who had been married four years and had borne three children: At the age of 17 she had suffered severely from bronchitis, and at a later date from dysentery. During her married life, although in good health, she steadily lost flesh. It was during May of 1879 that her first symptoms began. Her throat was sore and she had much sneezing. She went to the seaside for a week, and returned feeling quite well. During the early part of June her throat, nose, and eyes were irritable and the sneezing returned. In a little time she observed that her neck was becoming stiff, and the stiffness gradually spread to the arms, bust and face. Dr. —— was now for the first time consulted, and he at once said that the symptoms were arsenical. A month later (July) Mrs. B—— went to L—— and saw Dr. ——, who, knowing nothing of Dr. ——'s opinion, said that the condition was due to arsenic. During August, Mrs. B—— was from home at the seaside. Her skin was more stiff and slightly swollen (?) and the eyes were sore but the throat had recovered. During September an attack of diarrhœa occurred. In October Dr. —— again saw her, and again expressed the same opinion.

In the following February, eight months from the definite commencement of the stiffening of the skin, Mrs. B—— was brought to London and seen by Sir James Paget and myself. Her condition was then as follows: The skin of both upper extremities of the neck, shoulders, and face, and of the bust as low as the epigastrium, was stiff, rigid and board-like. It could not be pinched up. On the forearms this condition ceased just above the wrists, and the hands were quite free.

She complained, however, that her fingers were stiff and that she could not play the piano. No definite ivory patches could be distinguished, but there were many ill-defined streaks which much resembled a tallow candle in colour, and between these were streaks of erythema. Thus a mottled sort of marbling was produced. The white pallor of the streaks of the arms became much more apparent when the skin was stretched by extending the elbow. On the face the condition was less pronounced than on the arms and neck, and in the middle of chin and nose it could scarcely be appreciated. The cheeks showed little tufts of dilated vessels, but not so conspicuously as in some cases. Mrs. B—— said that her arms had formerly been much stiffer than at present, and that for a time she had been quite unable to put them behind her. I was told that the condition had varied considerably at different times, being sometimes better for a week or more and then worse. The skin always seemed more stiff after sleep, and became more supple during the day.

As to arsenic, it was at first believed that Mrs. B—— had been working with a Berlin wool which contained arsenic. The results of subsequent analyses, however, seemed to negative this suggestion, as not a trace of arsenic could be found in the wool. Nor was there any material quantity in any of the wall papers of her house.

Her feet and legs were but little affected. She said that she had been for ten months or more liable occasionally to red rings or wheals, which would increase in size for a time and then disappear, sometimes becoming as large as the palm of the hand. They come chiefly in the arms and chest. Her friends had told her that her eyes looked smaller, probably owing to contraction of the eyelids. Her pupils were active. Along the outer side of front of each elbow was a whitish tawny streak with brown edges. These streaks became more evident when the skin was stretched. She felt well, had good appetite, and slept well.

I saw Mrs. B—— again on Oct. 29, 1880. Her condition was much as before. The changes in the skin of the face did not attract attention until searched for, but were easily

recognized by the finger. She stated that she had been much better for a time, when suddenly, with change of weather, the skin became hard and tight again. She had recently been much less liable than formerly to catch cold, but exposure to cold always made her skin stiff. On Sept. 24, 1881, Mrs. B—— again came to London, when the following notes were made. She had an eruption of erythematous blotches last January, lasting two or three months. She has taken arsenic regularly for eighteen months, omitting three in the summer. It has agreed well on the whole. Her face is still stiff and marbled, especially over the malar bones. Is worse in damp weather, but not in cold or hot. Finger-ends not affected. The backs and palms a little stiff. She is not using any local application.

I have heard subsequently that Mrs. B—— has almost wholly recovered.

CASE III.—*Diffuse Morphœa, preceded by conditions resembling those of Raynaud's Disease—Death from acute catarrhal pneumonia.*

Dr. Hesse brought to me in November, 1885, a very interesting example of this combination. The patient was a German gentleman, who had long been residing in Yorkshire. He was of fair complexion, and had always enjoyed good health. He had been accustomed to use cold water very freely, both summer and winter, and had never experienced much inconvenience in doing so until a year ago. In the autumn of 1884, although the weather was not particularly cold, his wife used to notice that his fingers were always cold and dead when he came down to breakfast after his bath. She remonstrated with him about continuing it, but he asserted that it did not chill him, and that he was the better for it. His fingers, however, continued to "die," and after a time got stiff and hard. After a time some of the nails inflamed and became sore. A month or two later his wife discovered, what he had not noticed himself, that the skin of his entire body was becoming hard like leather. These changes had been in progress rather more than a year when

I saw him. His fingers were then slightly swollen, and almost as hard as wood ; they were mottled and tallowy, and their nails showed transverse ridges, and had become more convex than natural. His face was smooth and hard ; it was quite impossible to pinch up any part of his skin on the cheeks or forehead, and he could not either frown or smile.

The skin of his trunk and of all his limbs was involved in a similar condition, but in varying degrees in different parts. Thus on the chest and front of the neck it was very stiff, but on the back of the neck and on the shoulders it could be pinched. He said that he experienced no inconvenience from it, excepting on movements. He could not stoop easily, on account of the stiffness of the skin of his knees. His age was 49, but the entire absence of wrinkles on his forehead and face made him look much younger than he was. His fingers were so stiff that he could scarcely use them to dress himself.

The subject of the above notes resided at Bradford when he was a patient of the late Dr. Bronner, through whose kindness I was kept informed as to the further progress of the ailment. The use of glycerine was of some benefit in alleviating the stiffness of the skin, but did not effect much, and Mr. H——, in spite of internal treatment, lost flesh and strength. On December 2nd he went out in a bath-chair, and although very warmly wrapped up he took cold. An attack of pleuro-pneumonia followed. I give the details of his last illness in Dr. Bronner's own words. It appears to have been a typical case of catarrhal pneumonia, and the entire unconsciousness of danger on the part of the patient, the absence of pain, and the sudden termination, are features which I have observed in several similar illnesses. Probably the pneumonia had nothing whatever to do with the scleroderma.

“ On the 2nd of December he drove out as usual in a bath-chair, very warmly wrapped up. The weather was very cold and windy, and he seems to have caught cold then. I saw him only the following noon, apparently in his usual state, only complaining of a slight pain in his left side. He had waited for me to call before he got up, having no idea of being seriously ill. I found considerable dulness of posterior

part of thorax (both sides) up to the scapular regions, with extensive friction sounds all over posterior part of thorax, bronchial respiration, slight crepitation, a few rusty sputa, extremities cool, no dyspnœa whatever, and temperature 98°. He got so rapidly worse that in the evening the dulness had occupied the whole posterior part of thorax, whilst the anterior half was tympanitic all over. Temperature same, 98°, extremities cold. At 10 p.m. paracentesis of the chest was tried (pulse very small and about 120), but only about a tea-spoonful of clear serum escaped. He died the following noon, having been in a moribund state all night and morning, without much dyspnœa, free from all pain, so that he stated in the morning 'he was much better, thank God, and free from pain.' He remained conscious almost to the last, and had no idea that he was going to die.

"I was extremely sorry that I could not ascertain the state of viscera after death.

"P.S. I may quite as well state that, alarmed by the rapid progress of the disease, I called our physician, Dr. Major, in consultation ten hours after my first visit, when the patient was already moribund (cold extremities, threadlike pulse, but *not* livid, and no anxious breathing), the thorax was tapped with a trocar in two different places, but only very little clear serum escaped."

CASE IV.—*Diffuse Morphœa of extremities, face, and bust, with close alliance with Raynaud's Disease.*

I saw Miss F——, aged 23, residing at B——, on July 8, 1887, with Dr. M——.

Her hands were livid, changing frequently from almost black to a white lardaceous appearance. Her face was a little swollen and red, and covered with almost confluent stigmata. She had had small abscesses at the tips of many fingers. Her feet and toes were affected in a similar manner to her hands, but much less severely. The skin of her face and bust was affected, and was everywhere more or less rigid. Her lips were especially thin and board-like. On the forearms

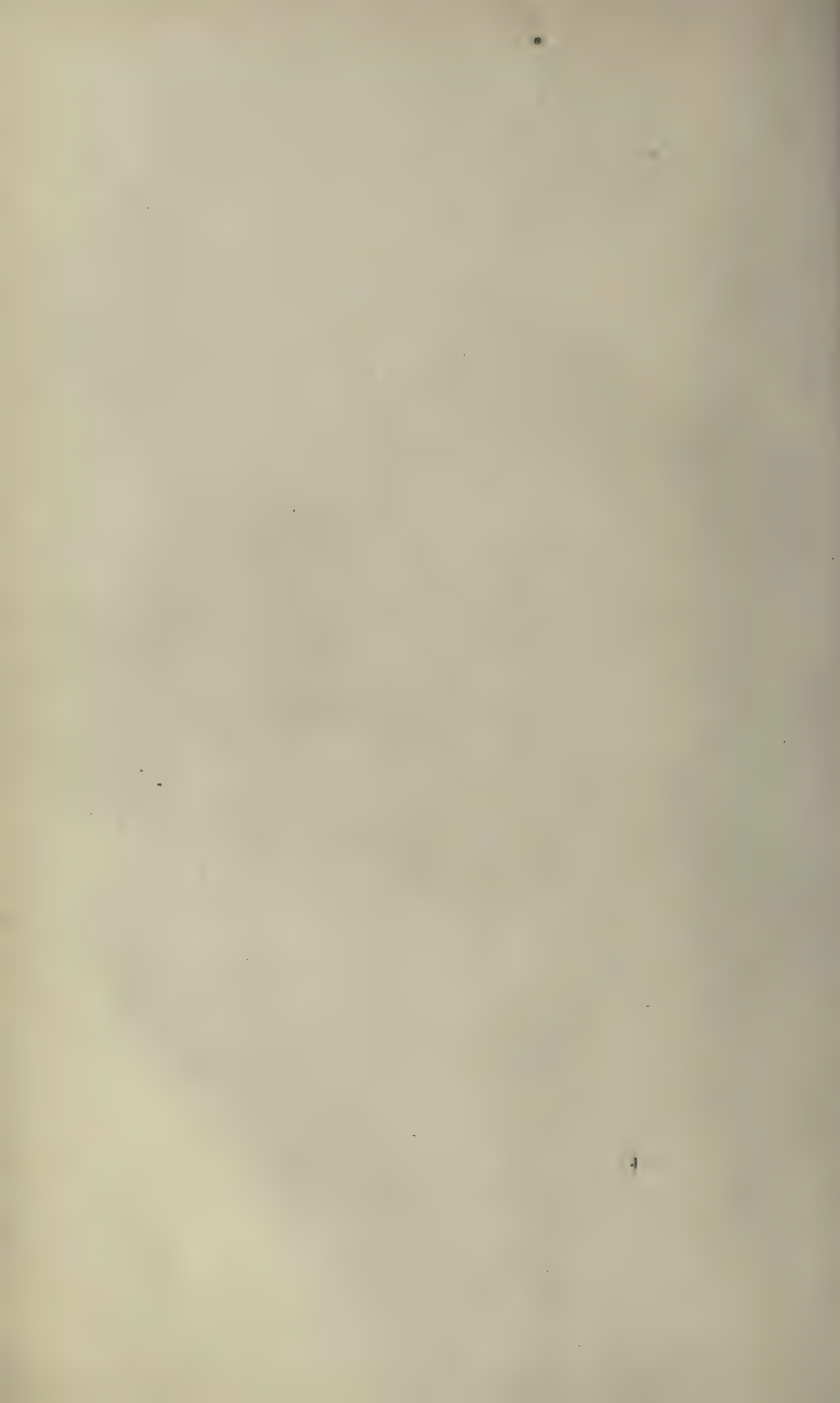
PLATE XXXI.

SYMMETRICAL GANGRENE OF EXTREMITIES WITH SCLERODERMIA.

SHOWS the condition of gangrene in the hand of Miss F——. It will be seen that the end of the left index finger is in a condition of gangrene. The finger is not mummified, but moist, and that the proximal portion is distinctly swollen. On a subsequent occasion, a year or two later, the other finger passed into a precisely similar condition. There was on this occasion decided inflammation of the hand, and bullæ formed on the adjacent parts. After the gangrenous part separated, the ulcer healed well. Attention is specially asked to the fact that in this case the fingers had not become slender and wooden, but retained a moderate degree of plumpness.

The case partook as much of the nature of Raynaud's disease as of sclerodermia, but it is to be remembered that the patient's face was in the condition of the latter malady. There can be no doubt that the two are often combined.





the state of hardness ended gradually a little above the wrists, or rather it diminished, so that it was not easily appreciated. The mammæ were fairly full, but the skin over them was decidedly tight. Her eyelids were not affected. She stated that in cold weather she became "stiff as a board in all her limbs," whilst hot weather made her "flushed and mottled as if she had an attack of measles." She was thin but rather florid, and of brown complexion. No remarkable tendency to chilblains had been observed. The history was that the condition had begun with slight swelling of the feet and arms. She felt at the time weak and poorly, but had no definite illness. I regret that I have not preserved sufficiently detailed statements as to the early stages. The case which is to follow is more conclusive on this point.

Additional Notes, 1889.

Miss F—— was sent to me again in 1889, about three years after the preceding notes were written out. Her hands were then in a deplorable condition. The end of the right forefinger was gangrenous, and in the pulps of several others there were deeply placed purulent bullæ. The severity with which the digits suffered seemed to be greatest at the thumbs, and to diminish onwards to the little fingers. Consequent on the destruction of the pulps of the fingers by "festers," a curious condition of loss of length in the nails had resulted. Thus the thumb-nails, although of normal breadth, were not more than a quarter of an inch in length. The nails of the little fingers had scarcely suffered, but all the others had in some degree.

I could not obtain any additional facts as to the early stages. Miss F—— thought that the condition had come on gradually, and that it had been increased, if not originated, by great grief at the death of her mother six years ago. A friend who was with her felt sure that it had begun after catching cold from exposure on a very snowy day, but of this Miss F—— herself had no very distinct impression.

Additional Notes, 1890.

I saw Miss F—— again in May of the present year, when she came on account of gangrene of the right forefinger. Thus we have an instance of what may be called delayed symmetry, for on the former occasion it was the end of her left forefinger which passed into gangrene. On the present occasion, as on the former one, the ring-finger is also affected. The sloughing process has been attended by intense pain, and there is now present a good deal of congestion and inflammatory cedema. The whole back of the hand is swollen. The skin of her hands is not particularly board-like, nor, as previously noted, are her fingers wooden. The skin of her forearms can still be pinched up. Thus it might be suggested that the conditions are rather those of Raynaud's disease than of sclerodermia. Her face, however, presents an appearance which any one experienced in the latter would at once recognize, its skin being tight, somewhat glossy, and covered with stigmata. She thinks, however, that her face is not so stiff as it formerly was. The palms of her hands are quite natural and plump. Miss F—— cannot explain her present relapse. She got well through the early part of the winter. It was in the beginning of March that her fingers passed into gangrene. She had been taking great care of herself, and had not been exposed to cold. She tells me that years ago her hands use to turn blue or even black; but that they do not do so now nearly so much as formerly. Her feet are often very cold, but no special changes have ever been noticed in the toes.

It is clear that we have in this case an example of symmetrical gangrene of the extremities, which fits well with the original description of that malady given by Raynaud. At the same time there are changes characteristic of diffuse sclerodermia. The case affords a good example of the alliance of the two maladies.

CASE V.—*Diffuse Sclerodermia of the face and extremities. Close alliance with Raynaud's Disease.*

Dr. Hughlings Jackson was kind enough to send me the subject of the following narrative.

Mrs. S——, aged 41, the mother of five children, had enjoyed good health until about three years before I saw her. She had, however, always been somewhat nervous, and never thought herself very strong. She had ten years ago suffered from small-pox. Her youngest child was about two years and a half old. She had never suffered much from chilblains. Her malady commenced according to her observation by the liability of her hands to “go purple.” “If I lifted them up to comb my hair all the blood would go out of them, and they looked as if they were dead.” After this liability had existed for two years “they began to swell a little and became set.” The liability to become stiff came on very gradually, but Mrs. S—— expressed herself as certain that it was not present at first, and that it had only become confirmed during the year preceding her visit to me. Thus it seemed certain that Raynaud's symptoms had preceded those of sclerodermia. When I saw her she was accustomed to suffer much pain from the cold. Her legs and feet were slightly œdematous, but the skin was not hard. Her toes were apt to die, and one of them was during the visit as white as a candle. Her face and upper extremities were hardened, the fingers being as stiff as wood. The hardness of skin was limited to exposed parts. It shaded off gradually on the neck, and was scarcely perceptible over the clavicles. Mrs. S—— reported that the upper arms, trunk, hips, and thighs were not at all affected.

We have here a very definite proof of the association of Raynaud's disease with sclerodermia. There could be no doubt that it had preceded and in some sense caused it. The sclerodermia had not spread to any perceptible degree to the parts which were protected by the dress. That the case in its latter stage had really become one of sclerodermia was proved by the implication of the whole face and by the wooden condition of the fingers. These states are not ordinary concomitants of Raynaud's disease, however protracted.

CASE VI.—*Feeling of “tightness” in the skin in a female aged eighteen—Want of pliability with a sense of resistance to the touch demonstrable in almost all parts except the scalp, ears, nipples, loins, flexures and prominences of the joints, and on the hands and feet—Changes noticed about one year. Supposed to have developed in about three months, and to have scarcely altered since.*

Helena Harper, æt 18, a nursemaid (residing at 343, Gray's Inn Road, N.*).

December 12, 1879.—She says that her attention was first called to her skin by a sense of “tightness,” chiefly in the arms. This was at the end of November of last year. She soon afterwards noticed white spots come out on the skin of the extremities, &c. These white spots were followed by red ones, such as can be seen now. The spots were very small, but made the skin feel rough.

The sense of tightness spread over the face, neck, chest, back, abdomen, upper and lower extremities, in the course of the next three months. The lower extremities, however, were much less affected than the rest.

She thinks that the state of the skin has not altered much during the last nine months. The skin has been very irritable, and this has led her to scratch much.

She does not perspire freely; she thinks scarcely at all.

She suffers much from cold hands and feet; has always done so, and has chilblains every winter.

She has not menstruated regularly for the last two years; about once in three months only. When this affection of the skin began she was merely helping in domestic work at home. Just before she noticed her skin becoming tight, she had been laid up in bed with a cold and cough. She does not appear to have had any rheumatic symptoms.

She complains that the tightness of the abdomen and chest

* I give the name and address of this patient, as in some other cases, in the hope that some of my medical friends may possibly be able to supply me with notes as to her present state.

affects her breathing. The neck is so stiff that she cannot turn her head from side to side properly. When she tries to do so, it seems to drag on her face and eyes.

To the eye there seems exceedingly little the matter with the skin except on the cheeks, where there is a rosy appearance combined with a shining, tense aspect and the smoothness of a wax model.

To the touch (with a few exceptions to be noted presently) the skin everywhere feels firm and resisting, and cannot be pinched up into a fold. The latter symptom varies in degree to some extent in the parts affected, but everywhere forms the most demonstrable condition.

The parts which are unaffected seem to be the hairy scalp, the ears, the middle line of the face (root of nose, upper lip, &c.), the nipples, the loins, and the portions of skin over prominent points of bones and in the bends of joints, and the hands and feet. The mucous membranes do not seem anywhere affected. I do not think that the middle line of face or the ears or even the nipples absolutely escape. It is only a question of lesser degree.

The forehead, cheeks, chin, sides of the neck, scapular and clavicular regions, and the upper and lower extremities, are the parts most concerned. The eyelids, mammae, and abdomen seem but slightly so, and the lower extremities less than the upper. The mammary regions are very decidedly affected. On the sides of the neck the integument feels almost board-like. The skin and subcutaneous fat of the forearms feel almost as stiff as in a rigid corpse.

The skin seems too short on the extremities, being put on the stretch too much on movement; so, also, on the neck and face. The change does not seem to go deeper than the subcutaneous tissue. There is no gluing to the bones, &c. The skin can be made to glide over the deeper parts. It is simply impossible to wrinkle it, or pinch it up into a fold. There is no desquamation of the epidermis. When on the stretch, the skin is, of course, pale. There does not seem to be any thickening of the skin; no deposit or growth in it, or in the subcutaneous tissue. The change shades off gradually into healthy conditions at the bends of the elbows, wrists, &c.

The cheeks do not appear to be thickened when grasped between the thumb and finger. There is no pitting on pressure anywhere.

On the extremities, upper part of chest, &c., there a few spots here and there showing abrasion of the epidermis or a covering of blood-crust, as if from scratching.

The above notes were kindly supplied to me by my friend, Mr. Waren Tay, when he sent the patient to me. The following are my own additions :—

December 20, 1879.—I do not discover the ivory patch anywhere. The nearest approach to it is on the sides of the neck, when on tension of the skin a sort of streaky marbling is produced by the white pallor between the rows of hair follicles.

I think that the platysma is tight, and that it is partly owing to it that she feels difficulty in turning the neck.

The exemption of the hands and feet is very definite and peculiar. I am not sure that the hands absolutely escape. The fingers have a slight degree of the feeling as if made of wood, but it is only little. They are of dull red with congestion, and the vessels fill slowly after emptying.

She complains much of cold, especially in her back. The legs are affected in slight degree; the feet not at all.

On all parts, but especially on neck and face, there are ill-defined scratched papules, a sort of abortive acne. She had been liable to spots on her face in summer for some years (Penmann's prurigo).

The state of the face closely resembles that of Mrs. Moore (narrated at length in my published lectures), and I have no doubt that it is the same condition differing chiefly in that the stage is less advanced.

I have no further particulars respecting this patient. No doubt she has been subsequently under the care of other observers; and should her case be recognized by any, it will be of much interest to put the sequel on record. It will be seen that eleven years have passed since the date of the last note.

No. VII.—*A case in which, during a long series of years, the conditions of diffuse Sclerodermia of the upper extremities and face had become developed—Alliance with Raynaud's disease.*

In May, 1881, my friend Dr. Stowers was kind enough to send for my examination the patient to whom the following notes refer.

She was a married woman, aged 49, and had suffered more or less since the age of 25. Her case has been reported briefly by Dr. Stowers in the Transactions of the London Meeting of the International Medical Congress (1881). She died, as Dr. Stowers informs me, of bronchitis in 1886. It would appear to be an example of the very insidious and slow progress of sclerodermic changes. In the early stages the disease was so indefinite that no diagnosis could be given.

When I saw Mrs. H——, her fingers were rigid and the skin of the hand and wrists stiff and hard. Her forearms also were stiff as regards pronation and supination, especially the right, which was the one first affected. The tips of her fingers had for long been accustomed to fester in cold weather, and also when it was very hot. She said that this liability began in her right hand as early as the age of twenty-four. The skin of her toes and feet was not rigid. The skin of her face looked tight and rigid, and showed many stigmata. She was aware of the presence of the latter and of some stiffness, but would scarcely admit that otherwise her face was affected. It was, however, as stiff as leather, and she could not wrinkle her brow in the least. That it had long been so was proved by her statement that ten years ago a dentist had remarked on the fact that she could not open her mouth on account of the rigidity of the lips. He said that he had never met with lips so stiff as hers. She believed that at the same date some florid spots were present on the cheeks. Even at much more distant dates, dentists had repeatedly commented on her stiff mouth. Mrs. H—— had suffered from eczema in one leg, and had passed through several attacks of an

erysipelatous kind, affecting on one occasion the leg, and on others the face.

I diagnosed the case as one of diffuse sclerodermia of the face and upper extremities. Its history would suggest that probably in the early stages conditions allied to Raynaud's phenomena had been experienced in the hands, and that they had passed very gradually into those of sclerosis.

PLATE XVII.

LATE STAGE OF SCLERODERMIA OR DIFFUSE MORPHŒA.

THE hands shown in this Plate offer a good example of the atrophic condition of diffuse morphœa or sclerodermia. The fingers have lost all plumpness, and become slender, pale, and wooden. The greater part of the hand is of wax-like pallor, but there are numerous patches of congestion (stigmata), like red seaweed, and here and there are a few little ulcers. It was quite impossible to pinch the skin up anywhere, as it was tight and parchment-like. Although there had been no gangrene of appreciable extent, the nails and tips of the fingers had suffered more or less. It is worth while to look carefully at the portrait, and note how symmetrical the changes are, and also to compare them with those shown in the next Plate, numbered Plate XXXI. It will be seen that in both hands the thumb has almost escaped (probably on account of its shortness); that the index and middle finger have suffered more than the ring; and that the little finger has had its terminal phalanx twisted and flexed. Similar statements are true of Miss F——'s hand, shown in Plate XXXI. With some minor differences, the same may be said of Plate XXX.





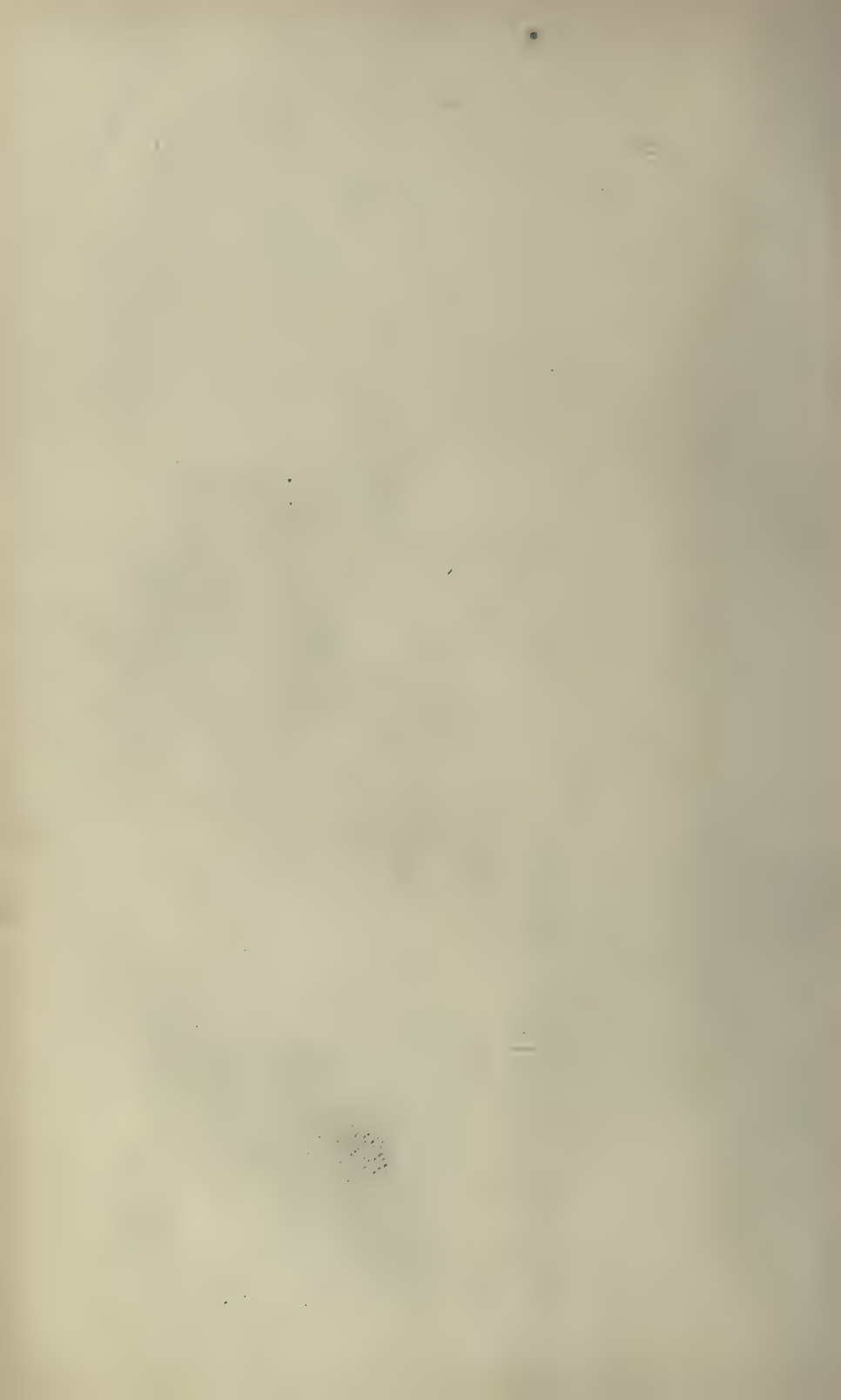
PLATE XXX.

LATE STAGE OF SCLERODERMIA OR DIFFUSE MORPHŒA.

THIS Plate and the following one illustrate the conditions shown in the hands in late stages of scleroderma or diffuse morphœa. It will be seen that the hands are pale and very thin, and the fingers slender. There are also many little scars about the fingers, and a few stigmata. The extremities of most of the digits have been damaged by inflammation occurring under the nail and in the pulp. These changes are tolerably symmetrical, and very like those shown in the next Plate. As a point of interesting detail, it may be noted that the little finger has its terminal phalanx twisted and flexed in all the five hands delineated in these three Plates (XVII., XXX., XXXI.).

Excellent models, showing conditions precisely similar to those illustrated in these Plates, are in the museum of the Hôpital St. Louis, at Paris.





ON HEREDITY IN REFERENCE TO DISEASE.

(Continued from page 306, Vol. I.)

THE attempt to determine in the human race the shares taken respectively by the male and female parent is beset with difficulty. A child may inherit the colour of eyes and hair from one parent and its mental habits from the other; but before we are entitled to assume that such apparent facts mean anything, we must ascertain the peculiarities in those respects not only of the parents but of their ancestors, for it may be that we have before us simply an example of atavism. The qualities in which human beings differ one from another are also so inextricably mixed up, are so little capable of accurate estimation, and shade into each other by such slight gradations, that it is exceedingly difficult to feel confidence either in our own impressions or those of our friends. A child may be reported by one observer as the image of its father, whilst another may see no likeness whatever. It is true that these difficulties are less when the cross is between individuals of different races, such, for instance, as the negro and the European. The free use of photography in the present day in the preservation of family portraits may in the future give us valuable help in reference to some of these questions. So also the observation and careful record of such marked peculiarities as myopia and hypermetropia, which are very definitely hereditary. We have, I think, as yet no facts as to whether they are transmitted more usually by direct or by diagonal inheritance.*

* Darwin states that his father communicated to him several striking instances in which, the father having long been dead, the son so strikingly resembled him in all features that it seemed as if his old friend had risen from his grave. He further relates, from his own experience, an instance of the descent of a peculiar habit from father to daughter. A boy had the habit when pleased of moving all his fingers rapidly, and when excited of raising both hands, the fingers still moving, to the sides of his face. When an old man, he could hardly resist this habit. Of eight children one only, a daughter, inherited this habit. She displayed it at the age of four and a half.

If we have recourse to the lower animals, and to the experience of breeders, we shall find, I believe, the same results. Whenever animals of dissimilar varieties or of different species are crossed, the result is invariably a mixture in the offspring of the qualities of the two parents. Prepotency may sometimes be exerted strongly, but never to the extent of producing a pure representative of the favoured parent. Nor is it possible, so far as I am aware, to assert anything as to the special qualities which are likely to be transmitted by either sex. Many breeders will give opinions very positively on this matter, but so far as I have gone they are always falsified by inquiry. It is not true that the father gives the nervous system and the mother assimilative organs, nor the reverse. The mixture appears to affect all parts of the organization, and although the degree of modification may vary much in different instances, yet it is never absent. Even in the cases where, as regards outward form, the resemblance to one or other parent may appear very close, some discrepancy will be detected, or perhaps the temper and mental character may wholly differ. Good opportunities for observing this often occur in those animals which produce several young at a birth. In rabbits and dogs, for instance, on crossing individuals of different varieties it is often observed that some of the litter may definitely resemble one parent, and others the other, but never, I believe, is this resemblance absolute. Nor, so far as I know, can the supposed law of diagonal transmission find any support from what is here witnessed. We do not find that the male offspring resemble their mother and the females their father. I am prepared to admit on other grounds that there is reason to believe that the male parent usually predominates slightly over the female in transmission to offspring. I deny that this law obtains any strong confirmation from the cross-breeding of the horse and ass. One other fact I may conveniently here advert to which does receive definite illustration, and that is that the size of the offspring is clearly more easily influenced by the female than the male. The mule is always, at any rate in England, a far larger animal than the mare. This is exactly what we should

expect if we remember that the fœtus is dependent for its nutrition upon its mother, and that the capacious pelvis and large blood supply of a mare, as contrasted with a she-ass, would be likely to conduce to its larger growth. The same influences will also tell after birth. No doubt size in the father has its influence on the size of the child, but not in the direct and, so to speak, double way in which the mother can influence it.

On One-Generation or Single-Family Prevalence.

Dr. Joseph Adams has insisted upon the important distinction between a *family* and an *hereditary* peculiarity, on the basis that the one is confined to a single generation, that is to brothers and sisters, and the second traceable through several generations. It is important that we should keep in mind this suggested distinction, for there are unquestionably some maladies which are prone to affect many individuals in one family, and others which rarely show themselves in many brothers and sisters, but are remarkable for their persistence in the race, as proved by their repeated, though possibly very sparing, reproduction in successive generations. So strong was the impression which Dr. Adams had received from this fact of single-family prevalence, that he held that what he called family diseases were rarely hereditary. In this strong statement I cannot but think that he almost wholly ignores atavism and prepotency. Reasoning in the same direction, he held that *congenital* diseases (those usually prevailing in families) were seldom hereditary. At another place, after admitting that congenital superfluities are sometimes inherited, this author writes that he believes such instances are rare, and adds, "Still, they ought to be distinguished from congenital diseases or privations, which always cease with those in whom they first appear." Again, he emphasizes this belief, and remarks, "By confounding hereditary with family diseases, we excite an unnecessary apprehension in the rising generation," and apparently he would have been quite willing to sanction the marriage of deaf mutes. He quotes Haller as remarking, "with much propriety," "*Cæci certe fere bene videntes pueros generant.*" This curious fact did not escape the notice of Sir

Henry Holland, who goes so far as to suggest that a disease not previously known in the stock may thus manifest a remarkable degree of what we may conveniently call *single family prevalence*. The instances which he gives, although of much value, are not of the kinds of disease most easily assignable to some one definite peculiarity. Thus in one family in which "neither father nor mother had been similarly affected, three sons and a daughter underwent an attack of hemiplegia before the age of forty-five." We are not told the cause of the hemiplegia, nor is there any statement as to possible atavism. In another instance three brothers suffered from hemiplegia at about the same period of life, there being no record of any similar event in the family. In a third, three sisters died with cerebral symptoms and fits at about the age of twenty-four; and in a fourth four children died in infancy with like conditions, there being in neither any known inheritance. Sir Henry thinks that these occurrences are chiefly to be noted in connexion with disorders of the nervous system, but he adduces also examples of it in the instances of diabetes mellitus in children, and organic disease of the heart.

I shall hereafter mention some facts as to ichthyosis and other maladies which remarkably illustrate this one-family prevalence. My belief is, however, that it is very seldom that this kind of prevalence is an absolutely new fact in the family. More usually it is intensification rather than origination with which we have to deal. This I have found (contrary to a previously existing impression in my own mind in conformity with Holland's opinion) to be remarkably the case in respect to ichthyosis. I am scarcely able to mention a single instance of one-generation prevalence in which there was not known inheritance, and when we recollect the facts as regards atavism, and the difficulties in procuring trustworthy histories, we shall not place too great reliance upon the absence of the latter.

Some of the best examples of one-generation prevalence occur in connexion with deaf-mutism, and to these, too, Holland gave special attention. He mentions the very striking fact

that at the school for the deaf and dumb in Manchester there were in 1837 a group of forty-eight children belonging to seventeen families. These families counted altogether 106 children, and thus there had been an average of nearly three deaf mutes in each family. Out of the seventeen there was but one instance in which the defect was known to have existed in either parent. We may indeed admit at once that it is not likely that we shall often find evidence of direct inheritance in the instance of deaf-mutism, since the subjects of this condition rarely marry.

Whether, however, we view it as the intensification of a tendency which has existed for long, and to which some pointings have usually been manifest in former generations, or as the actual origination of a new peculiarity, the facts remain very conspicuous, and, to some extent, difficult of explanation.* I will ask the reader, in the many examples of single-family prevalence which I shall have to examine, to note carefully whether there is any example in which the defect was really proved to be new, and whether the known possibilities as regards prepotency of one parent and atavic descent are not sufficient to fairly well explain almost all that we meet with.

I shall now pass to the citation of facts as regards a variety of malformations which are believed to be hereditary. Those which I select for discussion must be considered rather as illustrative types of certain classes, for it would be impossible to attempt anything like an exhaustive enumeration.

On Inheritance in respect to Hare-lip.

I do not know of many cases on record in which these failures of development by suppression (as of digits) have been observed to be prevalent in many members of one single family without inheritance from former generations.

With hare-lip and coloboma of the iris, both of them the

* Holland writes, "The extent and sudden development of disease in these instances may in itself be taken as the proof of new elements being introduced." He adds, "All physiology is at fault as to the solution of the phenomenon."

results of defective union of parts which ought to join completely during foetal life, the facts are different. It may easily be the case, however, that they appear to be different only because these defects are of common occurrence and the suppression of digits very rare. For it must be admitted that the one-family prevalence of hare-lip is very seldom seen, nor indeed do we frequently encounter facts which favour the belief that this defect is a matter of inherited tendency. The same is, I believe, true, but with less emphasis, of coloboma iridis and of defects in the junction of the genito-urinary organs, epispadias, hypospadias, &c. What I have to say about the heredity of hare-lip may probably be found to apply equally to these. A very large majority of the cases which we see are sporadic, and occur unassociated with any family history tending to throw light on the cause of their production. It is not usual to find them associated with other defects. Yet I have often heard of hare-lip occurring in several members of one family, and I have under my own observation a family in which a mother has borne twenty children, and nearly half of them have shown hare-lip. The extent of the deformity varies in different children. In other respects they are well developed.

On Heredity in reference to Club-foot.

Concerning the heredity of neuro-muscular malformations, such as those producing the ordinary forms of club-foot, I have little to say from my own knowledge. My experience would have led me to think that only seldom is there any family history of tendency to them, and that still more rarely is there observed any one-family prevalence.

I believe that such would also be the experience of most of those who have not made deformities of the feet a subject of special study. The observant among those who have done so, however, tell us a somewhat different story. They say that the congenital form of club-foot, "talipes varus," and its varieties, is almost always found to be more or less a matter of inheritance. Dr. Little, to whom I am specially indebted for information on this point, informs me that he has operated upon a grandfather, father, and son—three generations in

direct male descent—for the same form of congenital varus ; and he adds that he seldom sees an example of varus without finding that there is some history of the previous occurrence of the same deformity in the family of the patient. It is of great interest to know further that Dr. Little's experience has led him to the belief that, amongst the near relatives of those who have marked club-foot, there often occur minor forms of awkward formation of the extremity ; and yet further, that occasionally, when only one foot is affected, that some peculiarities may be noticed in the muscular supply of the hand of the same side, or of the eye. We must, I suppose, believe with Dr. Little and others that, in the production of congenital talipes varus it is the muscles which are at fault, and that the deformity results from the want of due balance between the two sets of muscles during intra-uterine life. Whether this is due to the nervous system, or is primarily a matter of muscle-development, it is not possible at present to decide ; but there is no doubt, as indeed Dr. Little has pointed out, that irregular action of muscles commencing long after birth may produce deformities which are precisely similar. Muscular deformities of the hand, of a nature analagous to talipes varus, are, as is well known, exceedingly rare. We have, however, in connection with the eye some very interesting facts in proof that defects in the development of its muscles, apparently quite unassociated with disease of the nervous system, may occur and may run in families. In the case of the foot it is almost always the gastrocnemius muscle which is mainly at fault, and in the eye, in a very large majority indeed, it is the levator palpebræ. Here, however, the analogy ends, for, whilst the gastrocnemius is usually well developed and too short, the levator of the lid is always too weak, and may occasionally be wholly wanting. I do not know that I could cite a more striking proof of the possibility of one single muscle being weakly developed than occurs in the instance of congenital ptosis. This condition is not infrequent, and we meet with it in the most various degrees of severity. Sometimes the lid hangs so low as almost to cover the eye, and the muscle appears to be absolutely wanting, and between this and the slightest perceptible degree of drooping

we have all degrees. Now and then, I believe, it is left to states of debility and want of tone in adult life to reveal for the first time the existence of this congenital effect. A slight form of symmetrical ptosis, which might be considered functional rather than organic, is met with not unfrequently in adults out of tone, and especially in ladies. I have seen it once in one eye only in a lady whose daughter was unquestionably the subject of slight congenital ptosis.

I have operated on a good many cases of congenital ptosis, and have sometimes had the history given of its being an inherited peculiarity. But I do not recollect ever to have seen it in many members of a single family. The same statement is, I believe, true of club-foot; although inherited, it is but little prone to show itself in more than one individual of a family. That congenital effects of the external muscles of the eye may, however, now and then prevail in families, we have interesting proof from a case of Dr. Heuck of Heidelberg. In this case a mother, herself the subject of complete congenital ptosis of both eyes, had four children. The eldest was born without any defect, but the three others, two boys and a girl, had congenital ptosis in degree almost as great as their mother. In both mother and children there was in this instance, in addition to the ptosis, great defect in the movement of the eyeballs, some of the muscles appearing to be almost paralysed, and others shortened. This case is of the more value because a post-mortem was obtained in one of the patients, and complete absence of one levator palpebrae, extreme thinning of another, was proved; this existed in conjunction with irregularities of insertion of most of the other muscles. The patients had no other defects, and the ocular nerves were normal.

Inheritance as illustrated in Coloboma.

Coloboma of the iris is often hereditary, and not unfrequently prevails in many members of the same family. When it does so, I think it is usually in its most simple form; at least this has been my own experience. I have several times known half the children of a large family affected by it, always with the history of inheritance, and

always with remarkable sameness in the different eyes, so far as the position of the cleft was concerned, and the absence of any more serious complication. The size of the cleft varied much, and in some of the children, instead of an actual cleft, there was present a wedge-shaped portion of iris which wanted colour, and looked exactly like a scar resulting from a closed cleft. In this feature congenital cleft of the iris is again a parallel with hare-lip. In the latter also we now and then see scars, as if a successful operation had been performed, but which were present at birth. I have myself seen this more than once, and Sir William Wilde mentions its occurrence both in hare-lip and coloboma iridis.

On the Inheritance of Supernumerary Digits.

There are certain congenital peculiarities of a nature wholly different from the defects and arrests of development which we have been considering, and which are far more prone than they to become matters of family inheritance. I allude to the production of superfluous structures, of which we find the best and most conspicuous examples in supernumerary digits. These cases are common, both in the lower animals and in man. The thumb, or the little finger, or the corresponding toes, are the digits to which usually the supernumerary is attached. The condition may affect a single digit; it may be symmetrical in the hands but not occur in the feet, or it may be found in both hands and both feet. It is attended occasionally by webbing of the digits, and in a variety of it there is an evident tendency to bifurcation at the end producing a more or less double nail and a large flattened thumb, but no positive supernumerary. The frequent co-existence of this partial bifurcation with supernumerary digits favours the belief that they are produced by similar methods. The mode of attachment of the supernumerary may vary much; sometimes it is united by bone to the metacarpal bone; sometimes it shares a joint, and at others it is suspended only by a very narrow pedicle. Of this latter condition I possess two illustrations, one taken from a patient of my own, the other copied. They both illustrate well the

almost absurd effect which the symmetry of these minor excesses of growth may produce.

I scarcely remember ever to have seen an instance of supernumerary digits in which there was not a history of inheritance. Usually it occurs to one or two in a family, irregularly, exempting the large majority, but transmitted through as many generations as are known about. Sometimes, however, single-family prevalence is very strikingly illustrated. I know a family in which it had been so troublesome, that, finally affecting six sisters together, they made a mutual resolution to prevent its further transmission by refusing to marry, and I believe kept it. Every writer on the inheritance mentions supernumerary digits, and assumes that the fact of their transmission is well acknowledged. They are of especial interest for us as affording a good opportunity for examining some of the laws on inheritance, for the malformation is conspicuous, and is rarely concealed in the family. They are of yet further interest because in them Mr. Darwin has found one of his boldest illustrations of what it may be possible for atavism to accomplish.

As regards the knowledge of the usual directions of transmission as illustrated by supernumerary digits, I believe it will be found that the facts are much what I have already hinted. Neither sex possesses in virtue of sex any degree of immunity or proclivity, and we find them occurring under the most varied conditions. A father may transmit them to son or daughter, and a mother to daughter or to son; the transmission may be continuous, or one or two generations may be overleaped. There appears to be no limit, and what we observe is a general slight tendency to transmission, augmented now and then, in all probability, by the unusual prepotency of an individual parent.

Dr. W. B. Sterling, of Nottingham Place, was kind enough some years ago to bring under my observation a very remarkable case of hereditary tendency to malformation of fingers. The history is valuable as showing that—which indeed many others do—the liability is not so much to any one special malformation as to miscellaneous derange-

ments of the normal conditions. We meet with webbed fingers, superfluous fingers, and double nails, in the same patient, or in different members of the same family. The boy who was brought to me was two months old. He had complete union of the middle and ring fingers in both hands, the union becoming closer and closer nearer to the nails, and the nails being in one piece. A thin web united the little and ring fingers. Superfluous little fingers had been present at birth, adherent by long, thin pedicles. One of these dropped off, and the other was snipped. On the feet all the toes were webbed excepting the little one, and the one next to it; the great toe on each foot was double, the two being firmly united together; the mother showed a scar on her left little finger where a superfluous digit had been removed in infancy. This had been her only defect. Her father had malformations of feet and hands almost exactly like his grandchild. He, as well as one of his sisters, inherited it from their mother, who, as well as one of her brothers, had united fingers. His maternal grandfather also had it, and defects of a similar kind had descended irregularly in various branches of the family, some having superfluous digits, and some only webbed ones.

The following is the list of the mother's brothers and sisters:—

1. A boy, superfluous little fingers only.
2. A boy, no defect.
3. A boy, superfluous little fingers only.
4. A boy, superfluous toe on one foot.
5. A boy, superfluous little fingers only.
6. The mother herself, one superfluous little finger.

Thus none of this family have had similar deformities to their father, whilst his grandchild almost repeats him.

The brothers and sisters of the infant whom I saw were two.

1. The eldest, a boy, with six toes on each foot, superfluous little fingers, and united fingers almost like his brother's.
2. A girl, free from deformity.

No special preference for either sex could be traced in this instance. It will be seen that there was direct immediate, mediate, and diagonal transmission.

Side by side with these defects of growth we often see hypertrophies, one finger too large and its fellow much too small. In such cases it is often difficult to guess whether the dwarfing or the overgrowth was the first step. In all probability they are usually related in some degree as cause and effect, and although perhaps not so as regards origination, yet the one favours the other, just as one twin often starves, dwarfs or even kills its brother by the demand made upon a supply of food not sufficient for both.

There are cases which we feel some difficulty in placing, the question being whether they should rank with the superfluities which we have just been considering, or with those due to foetal inclusion. In the one case clearly inheritance is possible, in the other not so. I allude especially to cases of double hands.

In 1867 I had an opportunity for examining the hand of a woman in whom the right fore-finger and its metacarpal bone were absent. There was no other deformity. She was not aware that she inherited the defect, and she had six living children none of whom showed it.

I have seen two examples of congenital absence of the radius, thumb and fore-finger. In each the deformity was on both sides and almost symmetrical. In neither instance was there any family history.

In another instance of deficiency of part of the ulna and imperfect development of the upper extremity, the subject, a man named Eaton, had five brothers and sisters with perfectly formed limbs.

Dupuytren's Contraction of Palmar-Fascia.

Gaubius relates as an instance of hereditary transmission the following:—"A little finger of a man began, from some cause or other, to grow inwardly, and became quite bent towards the palm of his hand. The eldest of his two sons, when at the age at which his father became affected with the deformity, observed that his little finger began to bend towards the palm. Different remedies were applied, but in vain. A younger brother employed preventive means, but

without effect. At the same period of his life, his little finger became bent, like that of his father and brother." We have here a good description of what is not infrequently observed in the contraction of the palmar-fascia. The condition of health, or perhaps rather of tissues giving tendency to it, is unquestionably sometimes hereditary, although I think but rarely in a strong degree. It is possible that it is in connection with the arthritic diathesis. The facts as regards its inheritance, the period of life at which it commences, the kind of patients attacked, and its steady progress in spite of all remedies excepting operation, find a remarkable parallel in the case of glaucoma. Most observers agree that the tendency to glaucoma is to some extent hereditary.

DISEASES OF ARTERIES.

(Continued from Vol. I. page 333.)

No. VI.—*Gangrene of the Feet in connexion with diabetes in senility—Advancing arterial thrombosis probable.*

I HAVE been attending with Dr. Horace Murray, of Highbury Park, a case of gangrene of the foot and leg, in which the progress of events made me suspect that conditions of arterial plugging similar to those described in my last number were in progress. The gangrene did not limit itself to the foot, but appeared also in the middle of the leg. The case is also an example of gangrene in connexion with diabetes.

I had first seen Mrs. B—— about two years before her death, and she then had a gangrenous ulcer on the left foot, near the base of the little toe, which went down to the bone. I was told by Dr. Murray that the urine had been known to contain sugar for several years. Mrs. B—— was, however, by no means in bad health. A small portion of bone exfoliated, and after a very protracted course the ulcer healed.

Mrs. B—— was brought to my house a second time about eighteen months after the first, and on this occasion it was for a gangrenous spot on the outer side of the heel of the other foot. It was strictly limited. A patch of blackened skin about the size of a five-shilling piece adhered firmly to the bone. A few months later I saw Mrs. B—— again, and the patch in a partly dry condition still adhered at its base, though loosened at its edges. The fatal illness set in in the beginning of May, 1890. Mrs. B—— had now been for ten years the subject of diabetes. Although somewhat gaunt looking, she was still in fair health. Her urine was of high specific gravity (1030), but not in very excessive quantity. The pulse at the wrist was of fair volume, and there was no proof

of calcareous deposit. Her tongue, as often seen in diabetes, was red and morbidly clean, owing to the absence of filiform papillæ. On this occasion, for the first time I visited Mrs. B—— at her home, as she was confined to bed. There had been an acute accession of gangrene. The foot was swollen, and over the dorsum of the toes was livid and cold, without any definite line of demarcation to the sloughing parts. She had had a good deal of pain, but it had now pretty much ceased. I could not find either of the tibial arteries, nor indeed the popliteal, whilst the pulsation even in the femoral itself was very feeble. The integument of the legs was in a state of senile atrophy, much thinned, and covered with the scars of boils.

Dr. Murray and myself carefully discussed the question as to the propriety of amputation above the knee. The state of the patient's tissues, her age (60), and the long duration of diabetes, were not encouraging facts, and we decided to wait and see whether the gangrene spread. I was somewhat influenced towards this conclusion by the fact that my last case of amputation in senile gangrene had not done well (see ARCHIVES, Vol. I. page 326). At the same time I had to remember that in a case very similar to the present one, which I have recorded in the Medico-Chirurgical Transactions, an amputation done under very desperate conditions was the means of saving the patient's life. In that instance the arteries were most extensively calcified, and the urine had contained both albumen and sugar.

I saw Mrs. B—— for the last time on Friday, May 23rd. She had become much worse, and was clearly about to sink. Her face had a leaden, dusky hue. She was sleepy, and when aroused often wandered in her replies to questions. The gangrenous patch on the dorsum of the foot was larger, and there was more general swelling of the foot and leg. A quite separate patch of gangrene had appeared on the middle of the front of the leg. The limb had nowhere assumed the tallowy condition so characteristic of the traumatic form of gangrene. It was slightly œdematous everywhere, and on the back of the calf there was a little redness. There was distinct tenderness over the lower part of the femoral vessels, but I could

not appreciate any swelling. I could not trace the femoral artery much below the groin, and it was very feeble there. The radial pulse was 103, and of fair volume. The hands were cool. The tongue was clean and beef-like, with a tendency to dry. My impression being that the patient had passed the stage in which it was in any degree likely that she could survive an amputation, I did not recommend it.

Mrs. B—— passed into coma soon after my visit, and died the next day. We could not obtain an autopsy.

No. VII.—*Obliteration of one Posterior Tibial Artery.*

My friend Dr. H——, aged 72, tells me that for more than a year he has been cognizant of the fact that the posterior tibial artery in his left foot is obliterated. The popliteal and the anterior tibial in the ankle both beat well, but no one is ever able to find the posterior behind the inner malleolus. On the other foot it is easily felt. The only results of this deficient blood supply are a sense of coldness and weakness in the foot, and some little pain at times. He always walks a little lame on first getting out of bed, owing to sense of weakness in this foot, but after a while it passes off. Dr. H—— is a tall man, of feeble heart, and rather dusky face.

No. VIII. — *On coldness of the feet produced by Tea.*

I advised a lady to drink more tea. "I cannot touch it," was her reply. "Why; what does it do to you?" "It makes my feet icy-cold, and wet with cold perspiration." On further inquiry she assured me that she was quite certain of her facts, and had often tested them. She thought that the perspiration was usually of the soles chiefly. Her hands were, she thought, also made cold, but not so definitely as her feet. I had long been familiar with the fact that tea made the feet cold, but did not know that cold perspiration attended it. It does not do so in all persons. The coldness is caused, I believe, by contraction of the arteries, for the feet at the same time shrink. Alcohol has usually a precisely opposite effect.

No. IX.—*Loco-motor Ataxy in remote connexion with Syphilis—Attacks of Arterial Anæsthesia.*

A case of threatened ataxy was presented in the case of Mr. L——, aged 37, who consulted me on April 23, 1888. His history was that he had had syphilis in 1871, for which he was several months under treatment. He had at the time he came to me a large lupoid sore on the right thigh, of six months' duration, and a large scar on the other knee, which Dr. A—— stated had been a large gumma which he had cured with the acid nitrate. His nerve symptoms were characteristic pains in the limbs, which kept him awake at night. He had no knee jump and the pupils were motionless, the left being larger than the right. The palpebral fissure was narrowed on the right side, and the eye looked retracted. On May 17th he was better, the lupus patch had healed, and he felt well. On Nov. 21 he came again for weakness and heavy feeling in the right eye. The left eyelid drooped. He had had herpes ophthalmicus in the right forehead three years ago after exposure to cold. In Nov., 1889, I again saw Mr. L——; he still had no knee jump, and the stabbing pains were present occasionally. He now complained of numbness in the feet; it was a cold feeling without objective chilliness, in both feet. The sensation was new to him. It seemed to be "arterial anæsthesia." (See ARCHIVES, Vol. I. page 329.)

On Feb. 4th he still had pains, but was better on the whole. The same sensations of chilliness were present in the toes.

No. X. — *Spontaneous cure of an unrecognized Aneurism of the Popliteal. Subsequent development of an aneurism in the fellow limb.*

A case of aneurism of the right popliteal artery was presented in Mr. J. W——, who came to me on October 5th, 1889. He was a tall man, aged 69, but not looking more than 60 at most; he had just returned from N. S. Wales. The history was that he had had a sprain of the muscles of the calf from walking on heavy ground in January, 1889. On the next morning there was some swelling behind the left

knee, which did not beat, and pain in the back of leg. The pain was constant, and he could not walk far, but he continued to do so a little for three or four months. After that he had very bad cramp in the calf for three or four nights, which kept him up all night. During the last of these nights, and after very severe pain and muscular cramp, he suddenly lost all sensation in the foot. The loss began at the toes and passed up to the instep; it alarmed him so much that he called his doctor up in the night. The cramp had ceased when the numbness came on. The numbness was as if the foot were wooden, but no sensation of pins and needles occurred. The doctor said there was no pulsation in artery below knee joint. This was in March, 1889.

On examination of the leg in October, 1889, I found absence of pulsation in the anterior and posterior tibial arteries of the left foot, and some indefinite thickening in the popliteal space. After seeking for the popliteal artery in the left side I turned to the other limb, and to my surprise found a large freely pulsating tumour just above the popliteal space; it extended upwards to the inner side up to Hunter's canal. It appeared to be the size of a fist, evenly rounded and elongated. It had an expansile heaving pulsation. In this limb of the anterior and posterior tibials could be felt. The girth above the knee on the right side was $17\frac{3}{4}$ inches, on the left $16\frac{3}{4}$ inches, with the leg resting flat. His pulse was 100; there was no calcification of arteries apparent.

So little trouble did this aneurism cause, that I was unable to persuade my patient to submit to any systematic treatment. He had not suspected the existence of the condition, and had consulted me only on account of the persisting weakness of the other leg.

DISEASES OF THE NERVOUS SYSTEM.

(Continued from page 352, Vol. I.)

No. XVI.—*Paralysis of Ocular Nerves at different times and of the sensory part of one fifth Nerve—Repeated treatment at Aix—Syphilis eighteen years ago—Lupus Erythematosus imitated in Syphilis—Locomotor Ataxy.*

Mr. F. K——, aged 49, came to me Sept. 10th, 1885. He was a widower when seventeen or eighteen years ago he had syphilis. It was a mild attack. Having married again fourteen years ago he had a second family, all of whom are living and healthy, the eldest being aged 13. Five years ago his right eye failed, and “he was obliged to shut one eye in order to see singly.” He was told that he must take mercury. He had at that time lost the power of his lips, and had a feeling of dampness in them; he was also very nervous. He went to Aix and saw Dr. Brandis, staying five weeks and using inunction. After returning from Aix (eighteen months before I saw him) he had paralysis of the right third nerve. “The lid drooped and the eye went outwards.” He again went to Aix, and stayed a long time and got quite well of his symptoms in the eye. He had never had any headache or pain. He has been altogether four times to Aix, always on account of eye symptoms and because he “was nervous”; the treatment there always did him good. He could always eat and sleep well, and thrive on the inunction. He has had “deadness of the face” on the right side which has never quite disappeared, and his tongue has a feeling “as if covered with flannel.” There are scars on the forehead and temple from a severe attack of herpes frontalis which occurred when under treatment at Aix a year ago. He has occasional rheumatic pains in

his legs and a sort of nerve twitching. The knee jump is quite lost, he thinks for some years; the pupils are small but equal; they scarcely dilate on shading, but act in accommodation. Lupus erythematosus began on his ears last winter, which he took to be chilblains. It was, when he came to me, very characteristic, spreading over his nose and cheeks in irregular patches which leave very thin pale scars when they recede. He still has scaly patches on his ears, chiefly on lobules. Sept. 22nd: The erythema-lupus is much better, on the right side it is almost gone; the patch on the left temple is still bright. He had chilblains almost for the first time last year. On Jan. 14th the face was quite well, but there has been a return of double vision. On Feb. 26th the diplopia had disappeared on the patient's being salivated. On Feb. 16, 1887, the patient reported his lupus erythematosus as having been quite well, excepting a lump like a chilblain in the lobule of the left ear. He has had two gastric crises and the right eye had diverged. He has some deafness and hissing noise in the right ear, and cannot hear the watch at more than half-an-inch. The affection of the ears has only been present three months.

February, 1890.—I have seen Mr. H—— several times recently. He is in fair health and quite free from lupus, but his ataxic symptoms slowly increase.

No. XVII.—*Herpes of the forearm and hand whilst taking Arsenic. Numbness of the fingers as a result.*

An elderly lady named J—— consulted me on account of an attack of shingles which had affected her forearm, fingers, and palm of hand. It had faded away when I saw her, but enough remained to show its character definitely. She had been taking liquor arsenicalis m xiv. three times a day for ten days before the herpes appeared. It had been ordered on account of chronic eczema on the scalp, by a medical friend.

This lady consulted me again six months later (on November 10th, 1890). I had forgotten all about her

shingles. She now complained that her finger-ends were numb. The fingers affected were the middle, index, and the thumb. I carefully tested the two sides of the ring-finger, and found its radial side a little numb, whilst the other was not so. She was much troubled about the numbness, as she often could not use her fingers well for writing, and could not put her thimble on.

This case illustrates several important points. First, the influence of arsenic in producing herpes zoster; secondly, the occurrence of zoster on the forearm and hand; and, thirdly, the production of numbness as a sequel of zoster in parts still more peripheral than those affected by the eruption. The first—zoster due to arsenic—is in my experience tolerably common. The second—zoster on the hand—is very rare. I have very seldom indeed seen zoster lower on the upper extremity than the elbow. It does, however, occasionally so occur, and here we have an example. As regards the last point, numbness of the skin supplied by the nerves implicated, it is according to ordinary rule. In this instance the numbness attracted the patient's attention more definitely because the fingers were the part affected. Zoster is a neuritis of a sensory nerve attended by an eruption, and it always more or less disorganizes the nerves implicated. The older the patient, the greater usually the degree of disorganization and the severity of the after-symptoms.

No. XVIII.—*Patient a young woman—Failure of sight without ophthalmoscopic changes—Hysteria suspected—Loss of use of the lower extremities, and total blindness—Complete recovery with white discs—Absence of menstruation for ten years—A brother also the subject of optic nerve changes.*

It happens not unfrequently in the course of consultation practice that a case which was at the time of its occurrence obscure and of uncertain diagnosis receives important elucidation by the reappearance of the patient, after a long interval. This has occurred to me in the case which I am about to relate.

A young lady whom I had seen several times in 1884 on account of failure of sight without obvious changes in the eye, passed from under my observation. She had an illness at home which confined her for some time to her bed, and concerning which I heard indirectly that the physicians who saw her considered it to be hysteria. During this illness she lost the use of her lower limbs and became for a few days quite blind. Her subsequent complete recovery was supposed to confirm the diagnosis of hysteria, and to negative that of neuritis (which I had given). I did not see the young lady between 1884 and 1890, and only heard indirectly that she had made, as I have said, a complete recovery. In January, 1890, her brother came under my care suffering from very peculiar eye symptoms, one element of which was pallor of the optic disc and appearances suggestive of long-past neuritis. He told me that a sister of his had been through an illness attended by blindness. I did not at the time identify my former patient, but thinking from what he said that his sister's case might throw some light on his own, I asked him to bring her with him at the next visit. I then found that his sister was the patient referred to above who had consulted me for failure of vision and other symptoms. I sought my notes of her case, and found the following on May 27, 1884:—

Age now 23. She is pale, forgetful, and very sleepy; she thinks that the sleepiness is due to her not being able to see. She trembles much, as if cold; walks feebly; sleeps well, but has to get up to make water in the night; she has once fallen down. No menstruation for four years; was seen by Sir Andrew Clark three years ago (July, 1881). Her urine is reported normal. She thinks her sight first failed six days ago and feels sure she could see well formerly. It has got worse during the last day or two. With the right eye she reads $\frac{3}{6}$ before and after atropine, with the left not $\frac{2}{60}$. The left disc is rather pale. No positive neuritis made out.

On June 6th she could read only 100 at 18" with left, with the right No. 8 Jaeger and $\frac{2}{60}$. The general symptoms were as before.

It was just after the above notes were taken (May and June, 1884) that Miss S—— was, as I have said above, confined to her house by increasing illness and I lost sight of her. I had diagnosed descending neuritis, and was in expectation of seeing definite changes in the discs. I heard subsequently several times from my friend Dr. D——, under

whose care she was, that she had been seen at home by one or more physicians, and that the diagnosis was, although with some misgiving, "hysteria." I can give no more definite information respecting this illness than that she lost the use of her lower extremities, and became either blind in both eyes or alleged that she was so. The condition referred to lasted only two or three weeks, and then she began to improve. Throughout the illness she had distressing headaches.

Miss S——'s recovery was finally all but complete. She regained the use of her lower limbs and her sight. She, however, never menstruated again. When she came under my notice in 1890 there was the most conclusive proof that her loss of sight had been due to neuritis, for the discs were now very pale and to some degree atrophied, and their edges were ill-defined. The diagnosis of past neuritis was given without hesitation by my son, to whom I showed the patient without communicating her history. Although the discs were in this condition, Miss S—— could see almost perfectly. She had regained the use of her legs so far that she could walk well any moderate distance. She was still a very nervous, excitable girl, and might have been easily supposed to be hysterical. She was reported to be impulsive, incapable of the slightest application, and to suffer much from nervous headaches. Thus she was quite unable to give any assistance to her sisters in a school which they had. She was exceedingly thin.

It is a point of some interest to ask what the precise nature of the illness was which Miss S—— passed through. Let us remember that it occurred to a nervous, hysterical girl who had not menstruated for four years, and in whom excessive masturbation was very possible. It consisted in an affection of the nervous system which revealed itself in a descending optic neuritis with headaches and paraplegia, and it was only transitory in duration, being followed by almost complete recovery. I make the suggestion of masturbation without having any facts to support it, for no questions were asked. It may easily be the fact that it is a very unjust suspicion.

There were other facts which seemed to indicate a family tendency to nerve disorder. Thus a younger brother has had defective sight from early boyhood, and his discs show evidences of past neuritis.

Dr. Buzzard devoted the Address with which he entered upon his presidency of the Neurological Society to an examination of what may be called the physical basis of hysteria. His remarks were very ably directed to the endeavour to show that the more the subject is studied, the more definitely are the phenomena of "hysterical" affections found to be dependent upon organic changes.

The case which I have recorded is one which will, I trust, be of some interest to my distinguished neurological colleague. The case might have been called "hysterical amaurosis;" indeed it was so called by several who saw the girl. When she became paraplegic, and alleged that she could not see, that diagnosis was persisted in. Her recovery seemed to confirm it. Had it not been for the ophthalmoscope the believers in functional defect might have triumphantly claimed the case. It might even have been thought to have been one of feigning. The state of the optic discs, however, makes it certain that the blindness was real, and due to inflammation of the optic nerves. We are surely justified in believing the paraplegia to have been of the same nature.

SYPHILIS.

No. XVIII.—*Are women liable to transmit Syphilis to offspring during longer periods than men?*

It seems probable that women who have themselves suffered from syphilis, and borne syphilitic offspring, retain the liability to transmit the disease much longer than men do. In my experience, if a series of children, one after the other, all suffer from inherited taint and show infantile symptoms, it is almost invariably the fact that the mother has had the disease. On the other hand, the cases are numerous in which the eldest only suffers and the rest are healthy, and in these the inheritance is usually from the father, the mother having never shown symptoms. Of course, even in these, it is to be admitted that probably the mother has received a protective infection (Colles' law), but not such a one as involves communication of the disease in an active form. This persistence of taint in women may possibly be explained by the fact that men usually secure longer and more efficient treatment than women do, or it may be due to some infection of the whole ovary and of all ova in the first instance. This latter supposition is the one which has been advanced as explanatory of the Lord Morton Quagga phenomena, and, though certainly not proven, it is a possibility which cannot be ignored.

In the following instance it would appear that the wife, who had before marriage suffered from syphilis, retained the power of producing tainted children eight years at least after her acquisition and in marriage with a healthy man. During this period she herself suffered but little, nothing indeed that was

definite, though it is probable that on several occasions she took specifics for short periods.

The rule of a two years' interval between syphilis and marriage in the case of a man appears, with exceedingly rare exceptions, to be trustworthy, but it may possibly be the fact that a much longer interval ought to be enforced in the case of women. It is, however, very certain that not all women who have suffered from syphilis continue to transmit it for long periods.

Mrs. B——, now aged 26, stated candidly that she had borne an illegitimate child at the age of 18. This infant died after a few months. She herself suffered from "the disease" at the time. An opportunity of marriage occurred to her about a year later, and she accepted it. Her husband was a respectable man, considerably older than herself, and concerning whom she feels confident that he never, either before or since his marriage, suffered from syphilis. She bore no children until two years after her marriage. A girl was then born who had slight infantile symptoms, who required treatment for a few months, and then got well. This child was brought to me for inspection (January, 1890). She is now five years old, a florid, pretty child, showing no indications of syphilis in her physiognomy. She has, however, a bald patch in the middle of her tongue, and her central incisor teeth are rotting away. A younger child (born two years later) also suffered in infancy. At the present time (aged three) he has superficial abruptly-margined ulcers extending over his palate. His incisor teeth are exactly like his sister's, and are rotting away at their crowns. His head is large and somewhat irregularly formed, but it cannot be said that there are definite bosses.

It is very remarkable that both these children should show symptoms of syphilis *in the mouth*, and in a chronic form. There appears no reason to distrust Mrs. B——'s statement, although various fallacies might be suggested. She has herself, at various times during her married life, been under treatment for glandular enlargements in the neck and other conditions which she attributes to "the disease," but there does not appear to have been anything very definite.

No. XIX.—*Congenital Syphilis—Disease of Testis at a very early age.*

T—— H——, aged five months, the third child; two others living, who are said to have had no symptoms. He snuffles badly, and has a dull, shiny, slightly scaly rash on face; withered aspect, and unusually well-marked hydrocephalus. There is considerable enlargement of right testis and epididymis, the cord is also slightly enlarged; it has been noticed six weeks, and is hard, painless, and not tender. The swelling is irregularly flat-sided (because involving epididymis), and it is uniformly hard.

No. XX.—*Not Struma but Syphilis—A fragment in connexion with the history of Diagnosis.*

As an item of medical history, the appended extract is perhaps worth preserving. It is from the Hospital Reports of the *Medical Times and Gazette*, under date, June 27, 1857, and was written by myself (anonymously). In it for the last time I applied the term “strumous” to the interstitial form of keratitis, now so generally recognized as due to inherited syphilis. The extract is of course given verbatim, and it will serve to show well the puzzle which the disease in question at that time presented. It shows also that the very peculiar clinical features of the disease, its remarkable tendency to spontaneous recovery, and the freedom of its subjects from obvious signs of scrofula, were well recognized. My papers upon it, in which for the first time it was claimed as a consequence of inherited taint of syphilis, appeared in the Moorfields Hospital Reports in 1858, and were reprinted in book form in 1870. Since then I believe I may say that all authorities in England and America have accepted the diagnosis, although it has not yet been quite so on the Continent:—

STRUMOUS (?) CORNEITIS.

“Mr. Critchett has devoted a very instructive portion of one of his excellent Clinical Lectures on Diseases of the Eye to the attempt to show that what is known as “strumous corneitis” is a disease of the causes of which we know very little, and over the progress of which no remedies have yet been proved to

possess any power. We speak of that form of chronic corneitis which occurs about the age of puberty, or from 20 to 35, and in which the whole cornea assumes a condition resembling ground glass. It usually affects first one eye, and then, after a month or two, the other also, and is never attended by ulceration. Mr. Critchett's statement is, that he has fairly tried all the vaunted remedies—mercurials, iodides, tonics, counter-irritants, &c., and has arrived at the conclusion that the disease is one which runs its own course despite of treatment, and in which, consequently, active meddling is worse than useless. The cheering part of the story is that its natural termination, even under circumstances the least promising, is always in complete recovery. The disease is a very well marked one, and very distinct from the common forms of ophthalmia. It is a rare affection, but the large field of observation afforded by the Moorfields Ophthalmic Hospital brings not a few examples of it under notice. One of such, of unusual interest, is now attending. Mary Ann H., aged 18, stout and florid, and not presenting any specific indications of struma. She was admitted in February of the present year with double corneitis. The right eye had been first affected about nine weeks before, and in spite of the treatment adopted by the medical man under whose care she had been, the disease had steadily advanced, and two weeks ago had attacked the left. The right cornea was so opaque that she could only just distinguish light from darkness; it was slightly conical in the centre, and presented a peculiar pink appearance. The left was in a similar but less advanced condition, and in both there was considerable sclerotic congestion. Menstruation was regular, and, excepting a feeble circulation, no indication of cachexia existed. Mr. Critchett ordered the Griffiths's mixture in ounce doses three times daily. The girl has attended regularly from that time to the present. At first the disease progressed steadily. For three months the patient was totally blind except to the perception of light, and so hopeless was the aspect of things, that Mr. Critchett several times remarked to his class that it was the most severe case of corneitis he had ever seen, and that he feared it would constitute an exception to the rule he had endeavoured to establish, that the disease was always recovered from. Ultimately, however, the case has falsified the fears entertained, and conformed itself to the rule referred to. The same tonic treatment has been continued throughout; and during the last six weeks so much improvement has taken place, that there is now every reason to expect that both corneæ will eventually clear."

I do not know what to write as to whether general opinion has changed as to Mr. Critchett's opinions on treatment. There is no doubt that many cases of interstitial keratitis resist specifics in the most remarkable manner, and that the disease often appears to run 'its course unchecked by them. In others, however, mercury does appear to cut the processes short, and to prevent the case passing into the more characteristic stages. That specific treatment should not have more definite results, and that, in a disease in which the diagnosis is so certain, we should still be in a position of

any doubt as to their efficacy, is certainly remarkable. Some of the worst cases which I have ever seen were in patients to whom mercury had been freely given; and, on the other hand, I have seen the occurrence of ptyalism put an end at once to pain and intolerance, and initiate a recovery which was afterwards uninterrupted.

No. XXI.—*Deaths from Inherited Syphilis in England and in Ireland compared.*

A statistical table, prepared by the Registration Office of Ireland for the use of the Vaccination Commission, shows that the number of deaths from inherited syphilis is steadily diminishing in that country. In 1865 the number of deaths from inherited syphilis registered was no fewer than 141, whilst in 1888 it was only 47. It is true that in the year preceding 1865 it had been only 107, and that in the year following it (1866) it fell suddenly to 75. But it rose again to 88 in 1867, whilst from that year onwards, with some irregularities, it has been declining. In 1887 it was only 31. It must be remembered that during the period concerned the population of Ireland had declined one-fifth. This decline in the mortality from infantile syphilis may be explained by reference to three considerations: 1. Improved treatment of infants affected; 2. Improved treatment of syphilis in the parents; and 3. Far greater caution on the part of surgeons in permitting marriage during the early years after an attack of syphilis.

In England there appears to have been a slight increase in deaths from inherited syphilis during the period in which in Ireland there has been a reduction. Thus, in the years 1863-7 the annual deaths from that disease per million births was 1,509; in 1873-7, 1,749; and in 1883-7, 1,884.*

Possibly the real explanation of these variations in both countries, and of the apparent discrepancy, is that in Ireland the population of towns is decreasing, whilst in England that of rural districts diminishes in relation to that of cities.

* I am indebted for these figures to the kindness of Dr. William Ogle.

No. XXII.—*Colles' Law—Is Protective Infection in any degree inherited?*

Under Colles' law, a woman who has borne to a syphilitic husband a syphilitic child becomes, although she has never herself shown any symptoms, protected against contagion. She may suckle her tainted child, and will not, as a wet-nurse might, get a chancre on her nipple. Now it is well known that often in such marriages the eldest child alone suffers, and that there may be a succession of healthy ones afterwards. Respecting these apparently untainted offspring of a father who has recovered, and a mother who has had the disease only in a modified form, some interesting questions may be suggested. Will they inherit in any degree their mother's protection? It may be this possibility explains the general belief that syphilis becomes milder in communities in which it has long and extensively prevailed. It may also explain the remarkable irregularities in the severity of the disease in different individuals.

DISEASES OF THE SKIN.

No. XXXV. — *Serpiginous Nævoid condition in the Skin (Nævus-Lupus).*

THE following notes of a case similar to the one illustrated in Plate IX. of my last ARCHIVES has been kindly sent me by Dr. Allan Jamieson of Edinburgh. It will be seen that we have in it an example of an infective nævoid process, spreading by its borders and producing satellites. In these features it approaches lupus. In my case there was a history of a nævoid stain at birth. In Dr. Jamieson's this history was absent, but for all that there may have been some congenital vascular peculiarity. I give the narrative in Dr. Jamieson's words:—

“A. T., 19, a tall, well-grown lad, came to the Edinburgh Royal Infirmary on Nov. 7, 1888. He stated that three or four years previously, after practising on the horizontal bar, he noticed a small red spot on the front of the right forearm, and since then the marks have slowly but steadily extended. The eruption, if such it can be called, is found scattered over the deltoid region, on the extensor and flexor aspects of the upper and fore-arm, and can be traced, though faintly, over the radial side of the wrist on to the back of the hand as far as the root of the thumb and forefinger. It consists of minute puncta, some set closely together so as to form groups, others isolated, some arranged in lines. The individual puncta vary in size from the diameter of a small pin to points scarcely recognizable unless with the aid of a lens. The larger are a dark, the smaller a clear red. In the spaces between the grouped puncta the skin is stained a faint pink. Pressure causes the smaller ones to grow faint, the staining to vanish, but in a few seconds the colour is restored. There are also several groups to be seen running along the inferior margin of

the fifth rib on the right side, from one inch inside the nipple to the margin of the sternum, the largest group lying next the nipple—the puncta here are clear and sharp and have no intermediate staining. There were no subjective symptoms. A small piece was removed from one of the groups on the arm, and serial sections were made from it after hardening by Dr. Edington. The horny layer of the epidermis was normal. The rete mucosum was also normal, but processes ran down from this in the spaces between the cones deep into the corium. The vascular loops at the apices of the papillæ were dilated into wide spaces, some of which still contained blood. The condition was evidently that of a very superficial capillary nævus, spreading by the formation of satellites—the isolated puncta. The process was perhaps started by strain of the minute muscles of the skin in gymnastic exercises.”

No. XXXVI.—*Lupus Lymphaticus with Nævus.*

I find that Mr. Bryant has recorded in the Pathological Society's Transactions of 1858, Vol. IX. p. 186, one of the earliest examples of this condition affecting a congenital nævus. The paper is accompanied by a coloured portrait, and a model is preserved in Guy's Hospital Museum. The boy, who was aged four when under Mr. Bryant's care, was born with a small red nævus on one buttock and general enlargement of the veins of the leg. The little nævus grew, and assumed “a warty and cystic” condition. The so-called “warts” were “soft and spongy, of a deep purple or red colour, and easily bleeding.” “The cysts were at times developed in them, or rather appear as if they were formed from them.” The portrait shows a long irregular patch on the buttock in a condition somewhat resembling lymph-lupus, but far more nævoid in character than in my cases. This condition is exactly that which was shown in the case exhibited at the same Society by Dr. Tilbury Fox in 1879 (see page 470, Vol. XXX.).

No. XXXVII.—*A peculiar form of Lupus with vascular tufts in scar—Ulceration of Ears.*

A remarkable example of destructive ulceration of the outer

part of the ear is sent to me by Dr. Batteson, of Bow. The patient, now a healthy-looking man aged 39, suffered in boyhood from what was then considered chilblains of the ears. He thinks it began about the age of nine and was bad until the age of fourteen, and then gradually got well spontaneously. He believes that his ears were usually worse in winter. He had chilblains also on his hands and feet, but these did not ulcerate. Before he was twenty his ears had got quite well. About four or five years ago a patch of lupus of a peculiar mixed form showed itself on the cheek of the right side just in front of the ear, and two or three years later a similar patch in the middle of the left cheek. The latter patch has left a condition of things exactly like that in Miss H——'s case; the peculiarity in both those two cases is that the scar tissue contains a great number of punctate vascular enlargements, little tufts which dot over the surface of the scar. Both in Miss H——'s case and in this the scar has in part resulted from the use of caustics, by which the lupoid disease is cured. Around the edges of the patch, as was the case in Miss H——, there is a little dusky erythema, quite different from the punctate condition of scar, and which probably represents the original condition of things, and shows a still existing tendency to spread.

A large irregular scar which has been left in front of his right ear is also slightly vascular, but not nearly so conspicuously so as that on the cheek. He states that the patch on the cheek frequently burns, while that on the other side seems quite cured.

Three near relatives have died of consumption, a brother and a paternal uncle and aunt. The condition of the ears is quite symmetrical. On each side the lobule of the ear, and the helix extending from the lobule three parts up the ear, has been destroyed.

The portrait of Miss H—— (see Plate 10, ARCHIVES, Vol. I.) shows exactly the conditions present in the scar in this case. They were very peculiar.

No. XXXVIII. — *Recurring Alopecia — History of Ringworm in the family.*

Miss A——, whom I saw on March 19, 1890, had a patch of alopecia which had only made its appearance a week before. She came in order to ask the question whether it was safe to go to a boarding-school on the Continent. Her history was peculiar. She was only fifteen years of age, but it was six years since her first attack of alopecia, and on three several occasions since the hair had grown and fallen again. It was four years since the last attack. It was not certain that she had ever had ringworm, but it had been in her family—brothers and sisters—seven or eight years ago. Thus it is clear that her first patch might have been ringworm, but the description was definite that it had been as smooth and clean as the present one, and respecting the latter there could be no doubt as to diagnosis.

No. XXXIX.—*Congenital Xeroderma (Ichthyosis) in slight form as a family disease—Diffuse Keratosis of palms and soles, developed in middle life as a result of excessive walking.*

J. W. M——, aged 42, consulted me on April 22, 1889. He presented an example of keratosis of palms and soles, with dryness of skin. Three of his sisters have xeroderma; he has five sisters and no brothers. His father had "hard hands." He has been married seventeen years, and has five healthy children; none of his children inherit dry skins, nor do those of his sisters, two of whom have families. He is a short stout man. His occupation is that of a traveller, walking and standing all day, sometimes doing twenty-five miles a day. It seems probable that he never had syphilis, though he had gonorrhœa twenty-one years ago. His chief complaint is the dry palms and soles, with a slight form of general xeroderma. Another complication has arisen lately which consists of some groups of red spots on fronts of elbows, groins, and about the ankles. He never could perspire well. He has lived freely, and not been more abstemious of late. His heels have been very horny

and have peeled. Between his toes the skin is white, thick, and soddened. He gets hot by exercise, but very rarely perspires. He likes hot weather, and has of late felt chilly. On the soles are thick masses of yellow horny epidermis, which peel off; over the heels the thickened epidermis was cracked. His palms and soles have itched very much.

August 27th, his soles were very much better, partly by rest and partly by arsenic. He has been using cork soles and tar ointments. The elbows and groins are now quite well.

No. XL.—*An eruption affecting the trunk only, and resembling those due to irritation from the vest but without any reason to suspect such causation.*

A lady aged 33, married, very stout, but apparently in excellent health, consulted me for one of these eruptions, under conditions which made it difficult to suspect the vest, for she had worn nothing next the skin of a woollen nature. She said that she could never bear wool to touch the skin, and that she always wore a thin cotton material. Her eruption, however, affected precisely the vest regions, that is the trunk, shoulders, and upper parts of the fore limbs. There were no spots on the head, neck, face, legs or arms.

When I saw Mrs. R. S—— (March 9th) the eruption had been out for a fortnight, and she had already had some treatment. It was plentiful, and consisted of erythematous spots of irregular forms, but seldom round, and which soon began to desquamate. There was no scale accumulation, nor any moisture. Between the breasts the spots were so abundant that they were almost confluent, and here the eruption threatened to assume the form of eczema. The spots were of a dusky tint, and excepting that they were desquamating might easily have been taken for syphilis. The history of its beginning was that it had first shown itself after she had been eating some fish, but it did not begin by a general outbreak, but by the appearance of a single patch on the abdomen, which she said looked like a ring-worm. Within a few days other spots showed themselves on the chest, and the eruption assumed the present pro-

portions. It had itched a good deal and she had rubbed it. None of the patches were in the least like urticaria, and it seemed very doubtful whether their occurrence had anything to do with diet or stomach disturbance. In essential features the eruption was exactly like others which I have described. It did not resemble ringworm, but few of its patches being round, and none of them in the least papular in their margins.

The case may be claimed by some as one of the group now known as pityriasis rosea.

No. XLI.—*Elephantiasis after Phlegmasia Dolens.*

In some cases of smooth elephantiasis in women the disease has taken its origin in the œdema which attends pregnancy, or in an attack of phlegmasia dolens after delivery.

The following case may illustrate this form of the disease. Mrs. L—— is a tall, remarkably fine-looking woman. She first came to me on April 19, 1884, being then 28 years of age. Her right leg was very much swollen, and had a large patch of red eczema. It had been inflamed, she said, for three years, and had been a little swollen for seven. The starting point was a much swollen leg during pregnancy, which never afterwards quite subsided. I prescribed lead and spirit lotion, and made her keep the couch. In the course of a few months the eczema was quite well and all sores healed, the œdema also being much reduced.

In the spring of 1885 Mrs. L—— returned with another attack of acute œdema in the same leg. A large bulla had formed.

In March, 1887, another similar attack occurred. The skin was red, and pitted on pressure. Although Mrs. L—— was well enough to come to my house, the attack was clearly of the type of erysipelas. She told me that during the last two years her leg had been almost well, and had allowed her to go about as usual without a bandage, but that it was permanently larger than the other, and always bulged in a roll over the top of her boot.

It is scarcely needful to remark that these recurring attacks

of erysipelatous swelling are essential parts of the development of elephantiasis. Each attack usually leaves the affected region permanently more swollen.

No. XLII.—*Acute Inflammation of the Spleen in association with Boils—Great enlargement—Abscess suspected—Long-continued high temperatures. Recovery.*

The following extract from the letter of an intelligent patient reporting his own case (in anticipation of his consultation) has interested me, and may prove of interest to my readers. Acute inflammation of the spleen is very rare in English practice, and that it should produce a condition suggestive of abscess is still more so. The long continuance of high temperatures and the completeness of the final recovery are also features of much interest. There was no trace of splenic enlargement when I saw the patient (two years after the date to which the extract refers), and he was then in good health.

“In the winter of 1886–7 I had two or three small carbuncles, which had to be lanced; also one or two very bad boils during the summer of 1887. At the beginning of November, 1887, I suffered pain and inconvenience from what I supposed was bad indigestion, especially pain on the left side, and on consulting my doctor he said I had better go into the country and enjoy myself; but I had to lay up, and, to his astonishment, when my wife suggested his taking my temperature, he found it was 105. A second opinion was called in, and I was immediately put to bed, where I remained for two months with an attack of acute inflammation of the spleen, and fever. A third gentleman said I must be ‘knifed,’ as it was ‘an abscess on the spleen.’ Fortunately Mr. D—, who was consulted, would not do it, but tried me with a needle, and proved that there was no abscess. I got well enough by the second week in February to go abroad for three months, and this quite put me up for a time. The boils, however, came on again every now and then, and I had a baddish one in my

leg, which healed by about the 9th of August. I have only just recovered from another one."

In searching for a cause for the spleen disease nothing definite could be made out. The patient was a man of 45, who had never resided out of England. He had an idea that he has suffered from some sort of ague, contracted at Torquay, when he was a lad of 15; but nothing had happened since to remind him of it. He had enjoyed good health, excepting the small carbuncles, up to the time of his acute illness with enlarged spleen. The illness was ushered in by chilliness, and it was this which led his wife to ask that the thermometer should be used. He assured me that for a month or more his temperatures varied from 104 to 105, and even to 106. The spleen was, he said, very obviously enlarged, even visibly so. One physician who saw him gave a confident opinion that there was abscess, and an operating surgeon was called in expressly to make an incision. Fortunately he declined, and the exploring trocar was used instead, with the result of obtaining only blood.

I could not ascertain any special cause for his liability to boils, which has now continued over two years. His urine has been repeatedly examined, and has never contained sugar. He looks well, and says that if he could live always in the country he feels sure that he should ail nothing. He suffers occasionally from indigestion.

Comments.—It will be seen that for the most remarkable points in the above case I trust to the patient's statements. He was, however, a highly educated man, and he had understood well what had taken place at his bedside, his medical advisers having treated him with confidence. Acute engorgement of the spleen, productive of such enlargement as to be taken for an abscess, is probably an exceedingly rare event. I have never myself seen such a case. The narrative is, I think, of great value, not only in reference to a diagnosis of a very critical kind, but also as to prognosis. Who could have foretold that a spleen enlarged to such a size would subside spontaneously and completely, and leave the patient again in good health?

ON RHEUMATISM AND GOUT.

(Continued from page 360, Vol. I.)

No. VI.—*Last-joint Arthritis affecting chiefly the fingers—No history of Arthritis in family known.*

DR. W—— was kind enough to send me on June 26, 1882, a remarkable example of this affection. All the digits of the hands were involved. In every finger the last joint was disorganized and the end clubbed. The nails were made opaque and fibrous. The ring fingers in each hand were slightly less affected than the others. The joints of the toes were very slightly affected, if at all, but their nails were rough.

Mrs. W——, aged 47, is a thin, rather delicate-looking woman of dark complexion. She never had any form of rheumatism until this commenced. She was then living in Brussels, and it was during midwinter that it began. She was not in any way exposed to cold or weather. The swelling began very insidiously, and there was not much aching. Gradually the swelling increased and the nails became opaque. Then there was some aching, but never severe pain.

No history of arthritis is known, but the family history does not go far back. Mrs. W—— has several children and they are healthy. She has not had any iritis.

When a girl she suffered a little from chilblains, but not very much. She has never been strong, but never specially ill. She used formerly to have very cold hands and feet—cold even in summer. Now they burn.

No. VII.—*Dupuytren's Contraction of Fascia affecting the soles as well as the palms.*

A man of about 55 had been the subject of Dupuytren's contraction of the palmar-fascia for several years. In his

hands it was symmetrical, both little fingers being pulled down, whilst the ring finger was only slightly affected. The interesting point in his case was that his feet were affected also. There was not any material contraction in the soles, but a long lumpy band of thickening in the plantar fascia. He appeared to be in good health, and was a florid man, not at all unlike a subject of gout. He did not admit, however, that gout had ever been known in his family. He had a lump as big as a hazel-nut, and almost as hard, in the lower part of the epididymis of the left testis; this had caused no symptoms. He said that of late he had been much kept awake at night by a curious pricking pain in his hands and feet. He had suffered from chronic rheumatism, and his left shoulder was considerably stiffened. He had been using galvanism lately, and considered that the pricking pains referred to had been made worse.

No. VIII.—*Arthritic changes induced by injuries in a brother and sister, both young, who inherited Gout.*

An interesting example of the importance of the family history, and of the manner in which rheumatic gout may be localized by injury, came under my notice in February, 1884. Mr. J——, a young gentleman, aged 20, was brought by his mother on account of pain and stiffness in the wrist and elbow remaining after a fall from his bicycle some months before. I found that his grandfather had suffered severely from gout, as also other members of the family. Having expressed my opinion that it was this inherited tendency which was the cause of the persistence of the swelling, his mother remarked it was wished that I should see his sister also. In the sister's case I found that great enlargement of the carpo-metacarpal joint of the right thumb had resulted from a sprain, and there was the further history that she had formerly been laid up for a year with chronic inflammation of one knee in consequence of a sprain. She was a florid girl of twenty, and had often suffered from rheumatism. Both she and her brother were accustomed to take wine and beer moderately.

No. IX.—*Ankylosis of wrist after Gonorrhœal Rheumatism.*

Mr. A—— (Sept. 19, 1888) afforded a good example of complete ankylosis at the wrist as a sequel of gonorrhœal rheumatism. The wrist was perfectly straight, and the ankylosis appeared to be absolute. A noteworthy feature was that pronation and supination were perfect. He said that he felt very little inconvenience from the condition, and could do almost anything with the hand. I have seen several other cases in which the entire loss of the radio-carpal joint has seemed to entail very little inconvenience. The important point is that pronation and supination should be retained.

No. X.—*An exceptional form of Dupuytren's Contraction of Palmar-Fascia.*

In a very large proportion of instances Dupuytren's contraction of the palmar-fascia affects the two ulnar fingers. The ring finger is often drawn down into the palm, and the little one more or less so, in cases in which all the others escape. I do not think that I have ever seen the middle finger affected alone to the entire exemption of the two first named, excepting in the instance about to be related. The patient was a gentleman of 80, of very large frame, and looking like a subject for gout, but who denied any history of that disorder either in himself or his family. His middle fingers in both hands were contracted until their tips almost touched the palm. None of the other fingers were contracted in the least, but there were lumps of induration in front of the thumbs and of one of the ring fingers. The symmetry of the condition was remarkable, proving that the preference of one part of the palm to the other was under the influence of some definite law of causation. The old gentleman was the subject at the same time of a peculiar form of leucoderma, which affected chiefly his fingers. This he said had been in progress many years.

No. XI.—*Gonorrhœal Rheumatism in a patient who inherited Gout—Slow recovery, with partially stiffened joints.*

I saw a gentleman named W——, aged about 25, with Dr. J——, at W——. His father had suffered much from gout. At the time of our consultation Mr. W—— was in bed, suffering from a severe attack of gonorrhœal rheumatism affecting one wrist and one instep. It was believed that he had sprained the instep in jumping from a boat, but whether this had much to do with it was questionable. He had been confined to bed for some weeks, and had suffered extreme pain. I saw him for a second time at my own house, about three months later, on his return from Bath. The wrist was stiffened to a considerable extent as regards flexion and extension and lateral movements; pronation and supination being perfect. The instep still remained somewhat swollen and painful, so that he could not walk well. He was tall and of dark complexion. At the time that the rheumatism set in he was suffering from gonorrhœa.

No. XII.—*An example of Hot Eye in connection with inherited Gout.*

A sister of Miss R——, whose case I have published in my lecture on the subject of inherited gout (see p. 379), has long been the subject of "Hot Eye." During these attacks, which have affected almost exclusively her left eye, the globe becomes red and hot with considerable pain. The attacks usually last a few days, and she says nothing does them so much good as a blister. When they pass off the eye is quite well. Having regard to the facts that her sister presents a most marked example of the destructive iritis of inherited gout, and that their relatives have suffered very severely from true gout, I think there can be little doubt that these attacks are of the same nature. It is interesting to note that they leave the eye quite undamaged. One of her aunts has lost both eyes from iritis.

NOTES ON THE CANCEROUS PROCESS AND ON NEW GROWTHS IN GENERAL.

(Continued from Vol. I., page 219.)

On the Spontaneous Disappearance of Malignant New Growths.

WHETHER new growths can disappear by spontaneous absorption is a question of some importance in reference to their essential pathology. In a general way we recognize it as an important and perhaps the paramount distinction between the products of inflammatory action and new growths, that the one are, and the others are not, capable of spontaneous removal by resolution or absorption. Yet we recognize a form of "atrophic scirrhus," and as an exceptional event I suppose that most of large experience have witnessed the shrivelling and disappearance of swellings which they had diagnosed as malignant neoplasms. Under such circumstances the diagnosis may not unfrequently come under suspicion. The disease known as Duhning's Neoplasm, or Granuloma Fungoides, is characterized by the spontaneous disappearance of some growths, whilst others are developing. For myself I may confess that I hail with pleasure all facts of a nature to break down the too strongly marked lines of distinction which it is customary to draw between inflammation and new growth. As such I record the following case, not the only one of its kind which I have seen, but certainly one in which the phenomena in question are well marked.

Miss K——, a dressmaker, aged 27, was sent to me by Dr. Cummings Air, of Norwood. She was a tall, gaunt-looking young woman, but did not consider herself much out of health. Her father was living, but her mother had died a

month after removal of a breast for cancer. Miss K—— had various “lumps” about her. In both breasts were cake-like masses of induration, chiefly near their periphery, which were very firm. In the subcutaneous cellular tissue of different parts there were several others. One as large as a fist, but flattened out, was placed over the right deltoid. It was tolerably well margined, adhered to the skin, but was movable on the parts beneath. A little lower down on the same arm there was a distinct hollow, where formerly she said a similar tumour had existed. This hollow had nothing of the nature of a subcutaneous scar, and there was no puckering. It was simply an absence of the cellular tissue. Another lump similar in character to that described was present in the right thigh, and others less definite on other parts. The lumps gave no pain, and there were no enlarged glands.

Her history was that the first lump noticed was in the right breast, and that it had never left her. It had not much increased since she first found it. This was two years ago. Soon after its discovery she was very weak and ill, and had tumours in various positions. She went into the Gloucester Infirmary, and was there under the care of Dr. P—— and Dr. R. B——. She was for some time confined to bed. There does not appear any reason to suspect syphilis, and she has never at any time had any skin disease whatever. She believes that there were formerly small lumps in her scalp, and that they have left “dents,” but about this I could not feel sure. She has irregular partially bald patches on the scalp, respecting the nature of which I could not entertain any definite opinion. She has four living brothers and sisters, one of the latter an invalid.

*An Example of the Spontaneous Disappearance of
New Growths.*

Mr. Marrant Baker has informed me of a case shown by Dr. Robert Liveing at the Dermatological Society, to which he thinks, with Dr. Liveing, the term “withering Sarcoma” might be aptly applied. The patient was a young man, in whom six or eight well-marked tumours had successively

developed in various parts of the scalp; one developing as another became shrunken and withered. Notwithstanding the history, Dr. Liveing came to the conclusion that the tumours must be sarcomatous; and his idea was subsequently confirmed. At the end of five or six years one of the tumours developed to a considerable size, and, unlike its predecessors, showed no sign of atrophy. The patient was at this time admitted into St. Bartholomew's Hospital, and the tumour removed by Mr. Marrant Baker. Under the microscope its structure was found to be that of a fibro-sarcoma.

Senile (black) Freckles, in association with Cancer of Skin.

Mrs. W——, an old lady of 70, offers another example of senile freckles in association with rodent cancer, and again the freckles are in proximity with the latter. The ulcer is on the right side of her nose, near the canthus, and is well characterized. The freckles, which are almost black, are on the cheek, just below the outer canthus on the same side. She has a few less marked in other parts. Her skin is in a state of senile atrophy. She is well aware of the freckles, and says that they have been there for several years. The rodent ulcer is more recent, and of not more than a year's duration. She has stigmata in both cheeks. She does not think that she was particularly liable to freckle when young.

Scirrhus in both Breasts, having begun at an early age in right, and slowly progressing.

Mrs. B——, 39, looking younger. Married eight or nine years ago. A miscarriage, but no living children. Six years ago ulceration occurred, and has gradually extended, with satellite tubercles in skin. There was a lump when she married, and had been for some years. It is therefore twelve years since the first lump was noticed.

Now a large, clean, cancerous ulcer, destroying the whole right breast, with an everted edge. It has caused very little pain, but much irritation at times.

A remarkable feature is the close simulation of a rodent edge. It has been called "epithelial cancer," but is clearly

scirrhus. The sore is very clean, and has been kept so by the use of water dressing.

*Three Operations for Cancer of the Lip in an old man.
Final cure.*

In reference to the non-recurrence of cancer of the lip after removal, the case of a Mr. R——, who is now aged 73, is of some interest and value. This gentleman had had a sore twice cut from the left part of his lower prolabium before he came to me with a third recurrence. The sore extended rather widely, but not deeply. For this reason I did not employ the usual V-shaped incision, but destroyed it very liberally indeed by means of the actual cautery. I find it described in my notes of March 12, 1874, as “an ulcer with hard edges, but without papillary growth.” In August, 1889, that is, fifteen years later, Mr. R—— came to me again for another disease, and I had the satisfaction of finding that his lip had remained quite sound.

A Case of Rodent Cancer—On Multiplicity of growths in connexion with senility.

Mr. D——, aged 68, is the subject of rodent cancer of his nose. I have repeatedly used the cautery, but it will be necessary to excise the ala. It is a typical rodent. The interesting point at present is that in his left eyebrow, just under a scar from a cut received years ago, a spreading, abruptly-margined patch is forming. The edge is like that of a nævus, consisting of dilated vessels. In its middle is a slightly marked scar. It does not really involve the old scar from the injury, but is near to it.

It may be of the nature of lupus erythematosus, or it may be a variety of rodent. I am interested in it as an example of two forms of serpiginous and malignant action in the same person and in connexion with senility.

THERAPEUTICS, DIET, Etc.

(Continued from Vol. I., page 76.)

No. IV.—*Does the presence of Albumenuria forbid the use of Mercury? Dr. Prichard's experience.*

THE question as to whether mercury is likely to be injurious in cases in which albumen is present in the urine, is one of much importance to the surgeon as well as the physician. Many surgical complications occur to patients who are the subjects of chronic renal disease, and conditions are often presented in which, were there not a prejudice against it, mercury would seem to be desirable. I have myself chiefly been concerned with this dilemma in cases of syphilis, and have long been in the habit of prescribing mercury without much regard to the state of urine. Nor have I ever seen reason to regret doing so. The following quotation from a Report on Medicine by the late Dr. Prichard, of Bristol (1835), is not without its interest in reference to this question. Dr. Prichard refers to cases in which dropsy was the condition requiring treatment.

“It seems to have been the opinion of Dr. Bright, and the observation was strenuously enforced by Dr. Blackall, that mercury is injurious in all cases of this description. I shall take the liberty to state that this question has been brought to the test of experiment, during several years, at the Bristol Infirmary. In numerous cases of dropsy, with albuminous urine, the treatment advised by Dr. Blackall has been fully tried, and it has failed to produce a cure; but the same cases terminated in recovery under a moderate use of mercurial remedies.”

No. V.—*On supposed Oyster-poisoning.*

The Sei-i-Kwai Medical Journal (Japan) for August, 1889,

contains a detailed report of an outbreak of supposed oyster-poisoning. Many lives were lost, and in some cases the whole family died. Cats also suffered. The illness was in all cases sudden and acute, attended by nausea, vomiting, griping pains, and hæmorrhagic eruptions. Coma usually preceded death. If the patient survived, convalescence was rapid. Experiments were made by feeding cats on the suspected oysters, and apparently with complete success. The oysters were from a bay which had long supplied them, but the special bed was a new discovery, and had furnished them in unwonted abundance. The epidemic entirely ceased as soon as the oysters were suspected and their use abandoned. The report makes reference to another by Professor Vaughan, of Michigan, in which nearly seventy persons were poisoned by oysters. In both cases the investigators believed that they had succeeded in isolating tyrotoxicon from the suspected molluscs.

It has long been known that under certain conditions mussels may become very poisonous, but the contamination has been supposed to result from their clinging to copper-bottomed vessels. In the case of oysters no such explanation can be offered. The more modern theory is that in both cases a poisonous ptomine is formed. It is said that a complete change of the bed will sometimes enable mussels to rid themselves of the poisonous quality, which latter is due to their being sickly.

No. VI.—*A very severe attack of Lichen Planus—Apparent aggravation of the disease under arsenic, and rapid recovery under tartar emetic with opium.*

The following account of a severe attack of lichen planus, is of interest in reference to the therapeutics of that malady.

Mr. F——, aged 49, was brought to me by Dr. T——, of M——, on July 26, 1887, for an extensive eruption of lichen planus. He was in good health and never before liable to skin disease, except on his elbows. It affected the abdomen, back, and limbs symmetrically. It did not occur

much on the thorax ; scarcely at all on the neck, and there was none on the face. The eruption had began on the front of the right wrist and was still most severe there, and there are a few spots in the palms of the hands. The spots were at first a little scaly, and it had been then diagnosed as psoriasis, but they soon become flat-topped and polished. It occurred freely about the navel. He had for years had little rough patches on his elbows which had, he thought, varied with his health. He had never had definite psoriasis, nor had these elbow-patches got worse since his lichen had come, but rather better. The eruption affected the fronts of his arms, but the outsides of his thighs had been exceedingly irritable from the beginning, and now kept him awake most of the night. There was no affection of the tongue or cheeks. Arsenic in full doses and tar solutions were prescribed.

On August 5th the eruption was more copious in the palms. It has been irritated by painting it with strong tar undiluted. There has been distressing itching at night.

On August 23rd the eruption had come out yet more freely, especially on the lower extremities. On the trunk it was still flat-topped, but on the arms it had become diffuse, almost like a dry eczema. It was diffuse on the soles and feet, but not on the legs. It was very erythematous and red, the redness disappearing on pressure. His soles smart and burn, especially in walking ; it has itched so much that he could not sleep. An application of tar made it burn for a few minutes, and then for two or three hours he was comfortable ; then it began to itch again. The palms of the hands were hard and horny, and the patches were extending. He stated that he did not sleep more than fourteen hours a week. Chloral would give him a good night. He had been a week in bed. His bowels were open, but motions pale. It was a most severe condition, and it seemed clear that arsenic in its present condition did not suit. He could scarcely walk from the tenderness in his soles. The face was still exempt. I advised that he should for a time keep his bed ; indeed his state was such that this seemed inevitable. I had on each occasion seen him in

consultation with his family surgeon, Dr. T——, who undertook the details of the treatment.

After the last note I neither saw nor heard anything of Mr. F—— for two years, and as he was worse than ever at the last visit, I felt sure that he had been laid up at home and had probably passed under other care. On April 1, 1890, however, he called to consult me about a sprained knee. Finding that he had been for long quite well of his lichen ruber and that his skin was now perfectly sound, I inquired how he had been cured. He replied that he had soon got well after my last prescription. As my recollection was that he was when I last saw him worse than he had ever been and that the disease showed no signs of yielding, I expressed some surprise. He assured me that he had consulted no one else and taken no other medicine. The eruption had, he thought, faded away in about six weeks after his last visit. Dr. T——, who first brought him to me and who was present at our last consultation, had since died, but Mr. F—— believed that the prescription could be found. I asked him to look it up and send it me. My recollection of it was that we were still pushing arsenic in full doses. The next day I received the prescriptions,* and found that the dates were as follows:—July 21, 1887. Fowler's and Pearson's solutions in doses of four minims each three times a day, and a tar lotion. This prescription was continued regularly until September 2nd, when the eruption being very profuse and exceedingly irritable, it was changed for one containing a quarter of a grain of tartarized antimony and twelve drops of nepenthe every four hours. It was under this latter and after the entire disuse of arsenic that the rapid cure resulted. I was assured that the irritation began to abate directly. It is to be stated also that the solution of tar was at the same date changed for a simple lead lotion, but I cannot think that this had much to do with the improvement.

* Mr. F——, in sending the prescriptions, wrote as follows: "I cannot distinctly remember how long I had to follow the *last* advice you gave me, but I probably carried it out about a month. Kindly note that the eruption gradually died away under the treatment you prescribed, and that I did not take one dose of any other medicine, or apply any other application."

I would by no means claim the merit of the recovery as definitely due to the antimony and opium, although I think it probable that they assisted materially. It will be seen that the doses were large. My reason for giving them so freely was that the skin was acutely inflamed and the patient in a most distressing state from irritation. In saying that I dare not claim for them with certainty the cure, I have in mind other cases in which, after the disuse of arsenic when it had seemed to increase irritation, recovery set in. Every now and then the benefit from arsenic seems to come after it is left off. This is only the case where it has appeared to definitely make the eruption worse; for if during a recovery under its employment it be left off, an immediate relapse is the usual consequence. I have often seen this in pemphigus and psoriasis cases. Probably in the case before us we gained in both ways, both from leaving off the arsenic and from giving the antimony and opium. That the latter remedies agreed well there can be no doubt, for Mr. F—— said that he soon got rid of his skin disease, and that his general health did not suffer in the least.

No. VII.—*Sea-air always disagreeing.*

A gentleman, aged 53, formerly a farmer, now retired, gives the interesting piece of evidence that he is always made worse by sea-air. He cannot even go within a few miles of the sea without beginning to ache in all his joints. He has repeatedly tried, but has always been obliged to go home within a few days. Hill air, on the contrary, always suits him. His most prominent symptoms are an inordinate craving for food, with much stomach flatulence after taking it. His tone is defective, and on one occasion he suffered for five weeks from fainting fits, so that he nearly died. He has been under several physicians, and followed very strictly plans of regimen without benefit. The indication seemed clear that he should live in a hilly district.

MISCELLANEOUS MEMORANDA.

No. VII.—*An Arabian Physician's motives.*

THE following impressive sentences are quoted from the preface to Rhazes (Sydenham Soc. edition). Rhazes wrote in the ninth century :—

“ In the name of God, the Compassionate, the Merciful. Abú Beer Mohammed Ibn Zacariyá (Rhazes himself) says : It happened on a certain night at a meeting at the house of a nobleman, of great goodness and excellence, and very anxious for the good of mankind, that, mention having been made of the Small-pox, I then spoke what came into my mind on that subject. Whereupon our host (may God favour men by prolonging the remainder of his life) wished me to compose a suitable, solid, and complete discourse on this disease, because there has not appeared up to this present time, either among the ancients or the moderns, an accurate and satisfactory account of it. And therefore I composed this discourse, hoping to receive my reward from the Almighty and Glorious God, and awaiting His good pleasure.”

On the choice of a Physician. An Arabian's plea for post graduate study.

From the same work that the above extract is quoted I take also the following, which may possibly be read with interest by the advocates of teaching for graduates :—

“ It is highly necessary to be considered, in the first place, in what manner the physician you intend to choose has employed his time, and how he has spent it in his private studies. If he has been very industrious in a diligent perusal and examination of the books of the ancient physicians, and has carefully read and compared their writings, we may form to ourselves a good opinion of him. On the contrary, if we find he has spent the greatest part of his time in anything rather than in what we have mentioned ; if he seems to be much delighted in music, drinking, and other ill habits, we can entertain no great opinion of him. But if it is evident

he has been all along very studious, the next point to be considered is, his genius and capacity, whether he has been very conversant with men able to dispute with and oppose him, and what just grounds we have to think he will ever arrive to the talents of inquiring into as well as of curing distempers. We ought to know, in the next place, what time he has spent in the conversation of those persons we just now mentioned, and whether he has acquired by their means the art of judging of a distemper as well as of relieving it. It will be material, moreover, to observe whether he well understands what he pretends to have studied or no : if we find he does, the next inquiry will be whether he has been used to attend the sick and happy in the cure of them. We ought to be satisfied whether he has practised in popular cities, where there are great numbers of patients as well as of physicians : and if upon inquiry we find that he is well qualified as to both these particulars, we may safely pronounce him an able physician, and to be made choice of before many others. But if it should be found he were failing in *one* of these qualifications, it were rather to be wished he were wanting in the practical part (I do not mean to be utterly unacquainted with at least some part of it) than to know nothing at all of the learning of the ancients. For he that is well versed in and has well digested the writings of the ancient physicians, will with a little help of practice easily attain to what others, who are wholly strange to this branch of learning, can never be able to compass : those I mean who know little themselves, and owe all the little knowledge they have to the long conversation they have had with others who have practised in places where both physicians and sick do abound. But if a pretender to letters sets up for a master without having any learning himself—or if he has some smattering, understands little of what he reads, or at least has not arrived to the use and understanding of his profession, such a one is not much to be relied upon, nor are his abilities to be confided in. Neither is it likely for him to become a proficient in his own way. For it is not possible for a man, though he lives to a great age, to attain to this part of knowledge so considerable in itself, unless he treads in the track of the ancients—the extent of this science far exceed-

ing the bounds of human life : and the same thing is not in this alone, but in many other professions. The authors who have improved this art are not a few, but they are not to be comprehended within the compass of a few years : a thousand writers, perhaps for a thousand years, have been improving this art and profession ; and he that industriously studies those authors will, in the short period of life, find out as much as if he had lived a thousand years himself, or employed those thousand years in the study of physic. But if the perusal of ancient authors comes once to be slighted, what can any single person find out, or what proportion can his personal abilities, though much superior to others, bear to the immense treasures of the ancients ? In short, he that reads not the books of the learned physicians, nor understands something of the nature of diseases even before he comes to visit, will, when he comes to attend the sick, either through ignorance or mistake, overlook the distemper, because he does not beforehand understand anything of it."

No. VIII.—*On the great value of clinical histories in connection with Museum specimens, and especially with drawings or models of Skin Diseases.*

It is impossible to exaggerate the importance of good case histories in association with specimens placed in museums. To take an example, the names given to many diseased conditions of the skin are still so arbitrary and so subject to vary with the opinions of the godfather or the critic, that it becomes almost essential that there should be connected with every model or plate a concise but detailed verbal description of the case, so that any one inspecting it may have all possible help in forming his own conclusions. This remark is illustrated by the fact that Sir Erasmus Wilson, in his naming of the French models in the College of Surgeons Museum, has ventured, and I think judiciously, to differ a good deal from the Paris authorities under whose directions they were made ; and I have no doubt that it will obtain further support from the yet differing opinions of almost every dermatological authority who visits the Museum. It is a great pity that some of these models are named only, and have no clinical

history attached. For my own part I would far rather have a model without any name whatever and with a simple statement, "This eruption occurred in a patient of such and such an age, and under such and such circumstances; was cured, or not, under such and such treatment, and it did or did not recur," than I would accept the nosology of any authority, however skilled and however careful in the use of his terms. A model with an erroneous name and without a history serves only to mislead the uninitiated and to embarrass those who understand the matter, but who under such conditions are able only to meet opinion by opinion without supporting their correction by the appeal to the recorded collateral facts. A specimen with a good history attached is made thereby far more than doubly valuable, for it becomes at once a clinical study almost as useful as that of the patient himself.

No. IX.—"*A Petrified Child.*"

The following extract is taken verbatim from Hall's "Encyclopædia," now a century old. It is clearly a description of a retained fœtus, probably extra-uterine. It might be of interest to know whether the specimen is still in existence. If the description is even approximately faithful, the extent to which calcification had proceeded would appear to have been very unusual.

"Bartholine, Paré, Licetus, and many other writers, give an account of a petrified child, which has seemed wholly incredible to some people. The child, however, which they describe, is still in being, and is kept as a great rarity in the King of Denmark's museum at Copenhagen. The woman who went big with this, lived at Sens in Champaign, in the year 1582; it was cut out of her belly, and was universally supposed to have lain there about twenty years. That it is a real human fœtus, and not artificial, is evident to the eye of any observer, and the upper part of it when examined, is found to be of a substance resembling the gypsum or stone of which they make the plaster of Paris: the lower part is much harder, the thighs and buttocks being perfect stone, of a reddish colour, and as hard as common quarry stone; the grain and surface of this part appear exactly like that of the

calculi, or stones taken out of human bladders, and the whole substance examined ever so nearly, and felt ever so carefully, appears to be absolute stone. It was carried from Sens to Paris, and there purchased by a goldsmith of Venice; and Frederick the Third, King of Denmark, purchased it at Venice of this man for a very large sum, and added it to his collection of rarities. Phil. Trans. No. 285, p. 1400."

No. X.—*New Diseases—A Fallacy.*

Boerhave writes with confidence: "The Venereal Disease began in the Kingdom of Naples since the year 1463, spread itself through the French Army there, from thence through Europe,"—he adds quaintly, "and is still a very common disease."

His commentator holds that it was referred to in Plutarch's Life of Otho. The expression quoted is, however, no more definite than "several diseases that he had contracted by conversing with lewd women," and it may refer to gonorrhœa, gleet, stricture, and the like.

Concerning *Rickets*, Boerhave in his aphorism 1486 thus expresses himself:—

"About the middle of the Sixteenth Century there arose a new Distemper in the Inland parts of England, spreading itself from thence through that whole Kingdom, and all the Northern Regions of Europe, called the Ricketts, now-a-days a very common Disease."

It is well to bear such statements as these in mind when we are investigating other questions as to asserted new developments of disease. If there is one malady which takes precedence of others in the probability that it has afflicted the human race from its beginning, it is Rickets, for it occurs in the lower animals also, and is essentially connected with damp dwellings, want of sunlight, and poor food. It is improbable that it ever had any sudden accession or material increase. Similar rumours are encountered as to the spread of Leprosy by the Romans, and subsequently by the Crusaders. Probably it as well as rickets was indigenous to many districts. All definite maladies appear to become more common as soon as they are well described and taken notice of.

ARCHIVES OF SURGERY.

OCTOBER, 1890.

BIRMINGHAM AND BERLIN.

NOTES FROM THE TWO CONGRESSES.

THE Annual Meeting of the British Medical Association was held this year at Birmingham, and in the following week the tenth Triennial International Congress of Physicians and Surgeons took place at Berlin. I was present at both, and both were occasions of great professional interest. I purpose in the following pages to mention briefly some of the subjects which chiefly claimed my attention. I must premise that my notes will be for the most part personal, and that I do not in the least profess to try to select what was really of most importance. This has already been ably done by others. I shall record only what fell under my own observation, and speak chiefly of things in which I had some share. To attempt more would be foreign to the proposed scope of my ARCHIVES.

The Annual Museum at the Birmingham Meeting was not fortunate in the rooms allotted to it. They were ill-lighted and too small, and, further, the best space was given up to tradesmen who had hired it. Surgical instrument makers, druggists, medical booksellers, and purveyors of patent foods, were well represented, but pathology and other more strictly professional subjects were somewhat pushed aside. Notwithstanding these disadvantages, however, there was much to be learnt if you cared to take trouble and seek for it. It was

needful, however, to seek very diligently and make many inquiries, or you might miss all the best things.

Mr. Oliver Pemberton exhibited, in two large folio volumes, a very valuable collection of drawings, some of them beautifully done. They illustrated most various subjects in relation to surgery and pathological anatomy, and some of them were well worthy of being reproduced.

From the Museum of Queen's College (Birmingham) a large number of the more important specimens had been judiciously selected, and were specially described in the catalogue.* This department of the Annual Museum is always a very useful one, and it is easily attended to by the local committee. It saves visitors a great deal of trouble to have selections of the best things made from the local museums, since they thereby escape the necessity of searching through the latter for themselves. Local exhibits, whether from public or private collections, ought indeed to constitute the principal part of the Annual Museum, for it is both expensive and very troublesome to send such things from a distance. I may here remark as regards objects from distant places, that drawings constitute by much the most convenient material for this purpose. I never visit an Annual Museum without regret that so few of these are usually shown. It is impossible without much risk of damage to send wax models or wet preparations, but a portfolio of drawings will travel easily and receive but little hurt.

Amongst the more interesting of the objects contributed from the Birmingham Museums were a series of examples of rare forms of disease of the heart and blood vessels, and another (chiefly obtained from operations by Mr. Lawson Tait) illustrating various forms of Ectopic gestation.

In the department of anatomy and physiology, Professor Cunningham's series of beautiful models, illustrative of cranio-cerebral topography and brain growth, were to be seen, and others of scarcely less interest by Dr. J. John Brooks, Professor Birmingham of Dublin, and others. Dr. Ernest Jacob, of Leeds, had some interesting specimens and drawings,

* This series had been arranged by Mr. Gilbert Barling, Dr. G. F. Crooke, and Dr. C. Martin, from the Pathological Museum of the College.

amongst the latter one of "advancing lymphangioma of the tongue." The disease was believed to have been congenital. Dr. Jacob brought some casts illustrating changes in the nutrition of the digits allied to Raynaud's disease, sclerodermia, and "last joint arthritis."

Renal and vesical calculi, tumours of the bladder, enlargements of the prostate, and the whole subject of diagnosis by the aid of the cystoscope, were, as might be expected, well illustrated—Mr. McGill of Leeds, Mr. Vincent Jackson of Wolverhampton, Mr. Hurry Fenwick of London, Mr. Southam of Manchester,* Mr. Bennett May, and Mr. Oliver Pemberton being amongst the principal contributors.

Mr. Vincent Jackson also showed "a drawing of a tuberculous ulcer on the tip of the tongue, and which was successfully removed from a middle-aged woman." It would be of interest to know what was the proof that the ulcer was tuberculous, and what has been the sequel of the case.

The following specimens shown by Mr. Bennett May, of Birmingham, were from cases of certainly very exceptional interest:—

A Toothplate with Teeth, successfully removed by Œsophagotomy, after fifteen months' impaction.

A piece of Bone lodged in Larynx for thirteen months, and successfully removed by Tracheotomy.

A Halfpenny successfully removed by Œsophagotomy from Mediastinum Thoracis, after four years' impaction.

An Enterolith successfully removed by Enterotomy from a case of intestinal obstruction.

I was in Birmingham only two days, and my duties as president of the Dermatological Section prevented my attending the meetings in any of the others. I can therefore only state that I was told that all the Sections were well filled and the discussions vigorously kept up.

* One of Mr. Southam's specimens was of especial interest for me, since it appeared to prove the influence of local irritation in the causation of cancer. It was described as follows in the catalogue:—"The bladder of a male, aged 40 years, containing a cancerous (epithelionic) tumour, which appears to have originated at the site of a recto-vesical fistula. The fistula, which had been present for about fifteen years, had followed the removal of a large calculus by lateral lithotomy."

In the Section for Dermatology we had arranged for a discussion on a special subject every day (three mornings). This did not leave much time for original papers, but a selected few of these latter were read.

On the first morning Dr. Radcliffe Crocker introduced the subject of Alopecia Areata, and to my great satisfaction avowed himself a convert to the belief in its parasitic origin and its alliance, if not its identity, with ringworm. He wished to distinguish one or more forms of the disease, but for the more common and well-marked cases he was willing to go back to the old name and call them "Tinea Decalvans." As these ARCHIVES are designed for the record of my own opinions and observations, I shall perhaps not be accused of undue egotism if, leaving my readers to consult Dr. Crocker's able paper in the pages of the Journals, I here reproduce only the substance of my own speech in the debate which followed.

I remarked that I had been greatly interested in Dr. Crocker's paper. It entirely confirmed the opinions which I had myself long held and taught on the subject. In a statistical paper based on the experiences of the disease at the Blackfriars Hospital for Skin Diseases, which I had published in the *Medical Times and Gazette* about thirty years ago, I had expressed the view that alopecia areata was distinct from ringworm, that it had no cryptogamic cause, and that it was for the most part not contagious. That paper had often been quoted by subsequent writers. I had, however, not long after it was written, seen reason to mistrust some of its conclusions, and as years had gone on and experience had ripened, I had felt more and more certain that the negative results of microscopic examinations had misled me. It was more than thirty years since that paper was written. During the last twenty years I had always held and taught that the common form of alopecia areata was in all probability a result of cryptogamic disease, and that it was in fact a sort of modified ringworm, or at any rate a sequel of that disease. I did not believe that it had a fungus of its own, but held rather that it depended upon that of ringworm. In a large majority of cases I held that alopecia

occurred in those who had previously suffered from ringworm, and often on precisely the same spots. My attention had first been drawn to this point by a remark made to me by a distinguished London physician, who was himself the subject of alopecia. This gentleman stated that he had in childhood suffered from ringworm, and that one troublesome patch was exactly where that of alopecia now occurred. Since then very numerous cases had come under my notice which confirmed this view. I had treated patients for alopecia whom I had myself previously treated for ringworm. I had also seen alopecia occur in a calf which was known to have had ringworm before. The interval between the two diseases might vary from a few months to many years. In more than one case an alopecia patient, who had at first denied any previous ringworm, had found on inquiry at home that he had really had it in childhood. Under the head of typical or common alopecia areata, I would include all cases in which the feature of areation was well marked. In these cases the patches had abrupt margins, spread at their edges, and were never symmetrically placed. They very frequently began on the occiput, and in these cases it might be suspected that the contagion was effected from the back of a chair. In cases in which alopecia was not a sequel of ringworm in early life, I believed that it occurred from direct contagion either from another alopecia patient or from ringworm. The cases of loss of hair which could be reasonably suspected of being of neurotic origin, were quite distinct from alopecia areata. The baldness was either symmetrical or definitely one-sided, never irregular. I believed that it was impossible for nerve causation to produce round patches, or to cause patches to spread at their edges. Areas of disease which were really neurotic always occurred in the distribution territories of nerves, and were never infective at their edges. Thus herpes and morphœa, our types of neurotic skin diseases, never prove serpiginous. Alopecia, on the contrary, is always so. When, in connection with alopecia, there is a history of dyspepsia or of headaches, &c., probably the connection is merely accidental. I had seen abundance of alopecia cases in those who were in excellent health. I congratulated the

author of the paper on his recognition of alopecia areata as one of the cryptogamic family, and felt sure that it was a decided step in advance.

On our second morning, Dr. Bulkley, of New York, read an interesting paper on Factitious Eruptions. It was replete with well-observed facts, but was perhaps too detailed for the occasion; and the pressure of other business did not permit of our entering on the discussion of its important topic. Dr. Mapother next read a paper on the use of mercury in the treatment of psoriasis. This interested me, because I have long held that mercury is beneficial to some extent in all forms of inflammation, and tends under all conditions to repress and restrain the processes of cell growth. It was even, as I remarked at the time, used and recommended as a remedy for psoriasis by some of the older surgeons (Turner, to wit). However, Dr. Mapother had new facts for us, and although I do not think—with our modern knowledge of what arsenic and chrysophanic acid can do—that we are likely again to fall back on mercury, yet I felt indebted to him for recalling attention to its influence on the disease.

One of the most interesting events of the Section was the demonstration by Dr. Brooke, of Manchester, of a most remarkable example of Lichen Spinulosus (it has many other names) in a child. He had been zealous enough to bring the child from Manchester for our inspection, and had prepared an excellent statement as to what prior observers had done in relation to this very rare malady. No doubt Mr. Brooke will publish a full account of the case when complete, and I will therefore not anticipate further than just to say that one most important and I think novel feature had been made out, namely, its contagiousness. The disease in the patient had been present only a few months, and already several other children in the family were suffering from a similar eruption. It may be conjectured that, although totally different in external appearances, the disease really belongs to the same family as Molluscum contagiosum. Both probably have their contagious element in some hitherto undiscovered psorosperm. It is a very remarkable feature, and one to which I have repeatedly asked attention in reference to molluscum, that its cause, whatever

it is, appears to be unable to perpetuate itself. The eruption always comes to a natural end after a certain duration. We never see cases of persistent molluscum contagiosum.

At our second morning meeting, Mr. Malcolm Morris introduced for discussion the subject of *Vaccination Eruptions*, and prefaced it by the following questions:—

1. Is there such a disease as “vaccine generalisée” due to blood infection; or are all the secondary vesicles, following vaccination, produced by external inoculation?

2. Are the general evanescent eruptions (Roseola, &c.), following vaccination, caused by a specific poison, or are they due to a foreign body in the blood acting mechanically (Behrend)?

3. Is it possible to transmit syphilis during the latent period by means of vaccination?

4. How is the occurrence of such apparently different skin affections as eczema, psoriasis, urticaria, pemphigus, &c., following vaccination, to be explained?

5. Is there any reason, so far as the protective influence of vaccination is concerned, why the vesicles should not be treated antiseptically, after the eighth day, so as to prevent the risk of accidental local inoculations?

In speaking of Mr. Malcolm Morris’s able paper, I endeavoured to keep close to his propositions. In the first place I avowed my belief in a true exanthem as a not very infrequent sequel of vaccination. All observers had, I thought, seen it, and the wonder was not that it should occur, but that it did not occur in all cases. It stood in the same position as the eruption after inoculation, and although usually very slight, might in some cases be severe. In some cases it might even be gangrenous. It was to be distinguished from all accidental eruptions, and especially from the so-called impetigo contagiosum, by the facts that it always occurred within a definite period, was always symmetrical, and always disappeared spontaneously after a short duration.

Impetigo contagiosum was, I suggested, an unfortunate name for an eruption which was always attended by vesications and never by pustules. The New Sydenham Society’s portrait might be taken as a good type illustration of the malady. The disease was just the same whether it begun from lice on

the head, from vaccination, or from a scratch on the hand. The pus secreted was contagious, in exceptional cases virulently so, and a whole household might suffer. I stated that I did not know of any severe English epidemics of this malady, but there had been many recorded on the Continent. The eruption was easily cured and left no ill consequences. Although it was necessary to give it a place as one of the occasional accidents from vaccination, it was unimportant.

As regards proposition No. II., I had to confess that I did not know what was meant.

In reference to the possibility of conveying syphilis from a vaccinifer who did not reveal the taint by any visible symptoms or any degree of cachexia, I felt bound in honesty to say that I felt sure of it. No surgeon in his senses would ever vaccinate from a child which showed obvious symptoms. The fact is, however, that a certain number of syphilitic infants look perfectly healthy whilst yet very efficiently contagious. There is no use, and much danger, in denying this important clinical fact. It has its parallel in the fact that many subjects of acquired syphilis pass through the secondary stage without a single symptom. I instanced the case of the vaccinifer in my first series of cases.* In this instance the vaccinifer was pronounced by the station-operator to be a good specimen of a healthy child, and was taken by a very able and judicious practitioner to a private house, for the purpose of arm-to-arm vaccination. Fourteen persons acquired syphilis, yet on the most careful examination of the infant afterwards nothing could be found of a suspicious nature, excepting a little sore at the anus. Concerning this latter, some, including Sir John Simon, who saw it, doubted whether it could be considered proof of taint. In my second series of cases the vaccinifer did not present a single visible symptom. Had it done so, it would have been rejected at once by the vaccinator, a well-experienced and very careful man. It is absurd to assert that inherited syphilis is always to be detected, and it is a cruel injustice to imply that all accidents have been the result of carelessness. Very fortunately it would appear to be the fact that but few syphilitic

* See Transactions of the Medico-Chirurgical Society.

infants have the virus in the vaccination lymph. No doubt many have been used as vaccinifers, and very few accidents have occurred. Dr. Cory's experiments support this view, for he, although using lymph from those who were known to be syphilitic, failed on several occasions. At last, by perseverance, he unfortunately succeeded. No good can possibly come from concealing from ourselves or others the real facts as regards the danger of syphilis from vaccination. Our only safety lies in their recognition. Not only must the careful vaccinator examine as to the state of health of the child he proposes to take lymph from, but he should know the parents, and will do wisely to avoid, as a rule, all first-born children. The cheering part of the story is that these accidents are very infrequent. Since the publication of my second series of cases in 18—, no single case of vaccination-syphilis has come under my observation. None have, I believe, been published in our English literature, and the officers of the vaccination department are able to assure us that, during twenty years of close attention to the matter, they have not found any amongst those vaccinated at their offices.* When we remember that during these periods a whole army of anti-vaccinators have been ceaselessly on the look out for facts by the help of which they might discredit vaccination, we may feel sure that in English practice during the last quarter of a century, at least, the communication of syphilis by vaccination has been infinitesimally small in amount. It would be a pleasure to myself if I might believe that the publicity given to the cases which came under my notice twelve years ago had been the means of causing increased care, and of thus helping towards the result of an entire absence of such cases during the last ten.

As regards the adoption of so-called antiseptic precautions in vaccination, I cannot say that I felt much zeal. I go, however, with Mr. Morris thus far that I think many cases of badly inflamed arms, of erysipelas, and contagious impetigo

* I make this statement on the authority of one given by Mr. Ernest Hart. It must not be understood to be more than literally true. It means simply that the vaccination officers have inquired for cases, and that none have been reported to them. It does not mean absolutely that none have occurred.

might be prevented if mothers were instructed to apply vaseline during the stage of scabbing, and to protect the arm with cotton-wool.

At the Hospital for Syphilis and Skin Diseases, Mr. Gilbert Smith had kindly collected for our inspection a group of rare cases. I will briefly record from memory what most interested me.

A boy of about fourteen showed that rare variety of cicatricial Keloid which assumes the pedunculated condition. As a rule, keloid sends out spurs into the adjoining skin, and its edges do not in the least become overlapping. Now and then, however, the growth is so free that the edges do overlap, and a sort of table with a very thick pedestal is produced. I have in several cases seen this condition developed to some extent, but never to anything like the degree present in Mr. Smith's patient. The finger could be put under the overhanging border at all parts, and the growth might be lifted away having a pedicle not more than a fourth of its whole extent. As usual in this form of keloid, the growth, although very firm, was less hard and much less glossy and smooth than in the more common variety which sends out spurs. It was exceedingly tempting for excision.

A young woman of about eighteen presented a good example of the eruption which is illustrated in plate of the New Sydenham Society's Atlas. It is an eruption to which I ventured to give the name of summer prurigo, or pruriginous acne of adolescents. Its peculiarity is that it affects the exposed parts, hands and face, is always worse in summer and nearly well in winter, and that it usually undergoes amelioration, or even disappears, when adult age is complete. The eruption consists of dull red papules which never suppurate, but always leave scars. They are scattered over the face and neck, and sometimes over the shoulders and back. Often, but not always, they are seen on the backs of the hands and forearms. They almost always itch and burn in hot weather. In the subject of the New Sydenham portrait, the disease entirely left the patient at the age of 22, after he had been during at least ten summers under my observation with it. It left him, however, with the skin of his face and shoulders marbled over

with scars. In certain cases in women, however, it persists through life. Mr. Gilbert Smith's case was an excellent example of the malady, and the patient gave the usual facts as to history. She was stout, florid, and in fairly good health. She had suffered for some years. She was, according to my experience, likely to do so some years longer. Some other observers present were inclined, I believe, to name the malady *urticaria perstans*, but its restriction to certain parts, the absence of true wheals, the conspicuous influence of sun and summer, and the fact that scars are produced, constitute features in which the malady differs from all forms of true *urticaria*.

A very delicate-looking woman of about 57 presented conditions which all present acknowledged as a somewhat exceptional form of bat's-wing lupus erythematosus of the face in association with a yet more exceptional form of eruption on the trunk. The opinions of the specialists present differed much as to how the latter should be named. It consisted of a faintly marked lichenoid and slightly erythematous eruption which covered the lower part of the back and buttocks in very large patches which in most parts had abrupt borders. Over the shoulders and upper part of the back there were here and there some very superficial scars which had apparently been left by the spreading eruption. Some thought that there must be syphilis in the case. Of this I could see no evidence, and my interest was claimed by the fact that the patches in the trunk were very like those which I have described at page 22 of *ARCHIVES*, Vol. I., in a case in which a lady became profoundly cachectic with persistingly high temperatures and an eruption which I held to be a variety of erythema-lupus. Mr. Smith's patient looked very feeble, and complained of being always very chilly. This symptom was present also in my case. The form of disease of the skin, so far as the body is concerned, is one which has not I believe been hitherto described. That on the face was a sort of connecting link between common lupus and the erythematous type. It is very unusual for lupus erythematosus to spread over the surface of the body, and when it does so it is always a very serious disease, often I think a fatal one. I have seen a few examples of it, and shall

have to mention presently a remarkable case, a wax model of which I had the pleasure of seeing subsequently in the temporary museum at the Berlin Congress.

Amongst the In-patients was one of very special interest to me, an example of paraplegia in an early stage of syphilis. The patient, a man of near thirty, had been of remarkable vigour. He was now in bed with almost absolute loss of sensation and motion in both lower extremities and incontinence of urine and feces. It was, I was told, only about nine months since his primary syphilis, and he had suffered from some secondary symptoms in throat and skin. Suddenly he began to have pain in his back, and in the course of a few days lost the use of his lower extremities, sensation failing at the same time. The reader may find at pages 148 and 188 of my work on Syphilis the narrative of a very similar case. I have seen but very few such, and have never had an opportunity for making an autopsy. The symptoms would point to a myelitis. The earlier in the course of the disease it occurs, the more severe it is and the less the probability of recovery. Yet in most cases probably recovery to a certain point does occur. In a clinical lecture some years ago published in one of the Journals, I recorded some examples of permanent recovery but with partially disabled extremities. They were, however, all instances of its occurrence at a later period of the malady.

My mission in Berlin (as an individual) chiefly concerned the desire to gain converts to the true faith as regards the cause of Leprosy. With that object I exhibited there (as had been done also at Birmingham) a "LEPROSY GLOBE," which is in itself an eloquent argument. It shows in the most striking manner that the disease chiefly prevails on islands, and along the sea-boards of continents, and that in these situations it may be met with over almost the whole world. I had opportunities afforded for bringing the subject forward for discussion twice: first in the Section for Dermatology, where the pathology of the disease was discussed, and subsequently, at the wish of Dr. Hirsch, in that for Climatology, over which he presided. On the latter occasion I dealt chiefly with geographical distribution, and the history of its decline in some places and increase in others. Many authorities on

the disease were present and took part in the debates, amongst whom may be mentioned Dr. Hirsch himself (the author of a most able and judicious article on it); Dr. Unna, of Hamburg; Dr. Arning, the Sandwich Island investigator; Dr. Peterson, of St. Petersburg, and Dr. Leloir, the author of the most recent and complete treatise on it. Without being able to say that any one distinctly avowed himself a believer in the fish-hypothesis, I yet believe that definite advance was made. The terms of the hypothesis had not been understood before, and I was told by several that, after hearing my arguments, they regarded it as a far more plausible theory than they had previously done. Above all, I am entitled to note that no one else advanced any hypothesis whatever as to cause, and that although Leloir and others stood up for the theory of spread by contagion, and Dr. Hirsch for that by heredity, others expressed great scepticism on both these points. A paper was read by Dr. Beaven Rake (who was not present) which to some extent supported my views. Dr. Arning had with him some valuable photographs, and exhibited in the museum an important series of casts, &c. From him I got the most valuable new fact which was elicited in the whole discussion, and one the knowledge of which would alone have repaid me for the journey to Berlin. Ever since attention was attracted (some twenty years ago) to the remarkable spreading of leprosy in the Sandwich Islands, I have expressed the belief that some new methods of cookery, or some novel form of fish-food, must have been introduced by the Chinese. All believe that the Chinese spread the disease, but have assumed without exception that it has been by contagion and not by food. Dr. Arning told us that it was undoubtedly true that, although fish had been largely consumed by the natives long before leprosy became prevalent, yet that the use of it in a salted state was new. Although not introduced by the Chinese, its employment had been about simultaneous with their immigration. This was exactly the fact which I wanted, for SALT fish is precisely the article most under suspicion as the cause of the disease.*

* The use of fish in a salted state has become so common now, that the lepers in the settlement at Molokai receive a daily allowance of near a pound a day, chiefly salmon.

In the discussion on Leprosy before the Dermatological Section I defended the following propositions, which, with a view to definiteness, I had had printed and put into the hands of those present.

Leprosy is everywhere the same disease.

The discovery of the *Lepra bacillus* has made the problem of the cause of Leprosy much more simple.

It is certain that the bacillus must be received into the body either by direct contagion or in the form of food.

It is certain that neither contagion nor hereditary transmission take any important part in the spread of Leprosy.

Englishmen who have acquired Leprosy abroad may return home and live amongst their friends without risk of communicating the disease.

Englishmen who, without any possibility of inheritance, go to reside in leprosy districts, may become Lepers, and without any known exposure to contagion.

It is clear then that the bacillus of Leprosy must in almost all instances be received in the form of food.

The only kind of food open to suspicion in *all* the various regions where Leprosy is endemic is Fish.

The statements adverse to the Fish-hypothesis of Leprosy will probably in the future be found to depend upon errors in observation.

The department of the Berlin Congress Museum which most interested me was a series of models and photographs collected by Dr. Lassar. Some of these were so good that it was almost equivalent to inspecting the patients themselves. Unfortunately little or no attempt was made to give information as to the case-histories, and the diagnoses recorded in the names appended were not in all instances out of the reach of debate. A magnificent model in the centre represented the head and bust of a young man, the subject of the very rare form of *Lupus erythematosus* which spreads over the whole body. I have already, in speaking of one of Mr. Gilbert Smith's cases at Birmingham, adverted to this malady (see p. 108). Dr. Lassar's model showed the chest, shoulders, neck, and ears occupied by diffuse erythema, which was desquamating in parts. How far it extended down the trunk could not be seen. On the face and scalp were quite characteristic conditions of erythema-lupus in isolated patches. There were some superficial scars. Curiously the one hand which was shown was not severely affected, there being only a single patch on the back of it. On the scalp the

hair had been extensively destroyed, large bald patches remaining in a state of partial cicatrix, and with scattered tufts of hair collected in the brush-like manner. The ears were red and swollen, but not ulcerated. From the nose itself and the adjacent parts of cheeks and forehead, the disease appeared to have receded.

Dr. Lassar showed also many models illustrating the effects of treatment in lupus, acne, rhinophyma, &c., and one in which congenital ichthyosis, of the black papillary type, had been almost cured (presumably by cutting or scraping the growths away). There was also one model showing a form of psoriasis inflammation affecting the scars left by cupping. The patient had apparently been the subject of psoriasis before the cupping. Dr. Payne, who examined these models with me, told me that he had seen common psoriasis occasionally evoked by injuries, and it is probable that its preference for the elbows and knees is to some extent due to the pressure to which those regions are exposed.

By far the most interesting to myself of Dr. Lassar's collection was, however, one which was labelled *Lupus erythematosus*, and which showed a serpiginous nævoid condition on the forearm and hand of a young child. Plate IX. in the *ARCHIVES* illustrates exactly the same disease, and when I published it six months ago I believed the case to be unique. Dr. Jamieson of Edinburgh was good enough on reading it to send me the narrative of a similar one, which the reader may find at page 71. The peculiarities of the condition are that an exceedingly superficial florid stippling of the skin spreads in a serpiginous manner over the limb during the course of years, producing satellites and leaving very delicate scars. In my case there was the history of a very small congenital nævus as the point of origin, but the young lady when I saw her was fifteen, and the disease was still spreading. It is clearly an infective process, and little outlying discs are produced totally unlike anything which we recognize in ordinary nævus. These discs spread at their edges and become rings. The reader must be good enough to turn to the plate if he would get a good idea of what is meant, and he may accept my assurance that Dr. Lassar's model was in all respects

exactly like my drawing.* In Dr. Lassar's the disease had spread from above the elbow over the whole of one side of the forearm, and to the hand even to the end of the thumb. The conditions were most pronounced near the elbow, and became very faint in the hand, just as will be seen in my portrait. Dr. Lassar named his *Lupus erythematosus*, and no mention was made of *nævus*; but as it was clearly the arm of a young child, the suspicion that some slightly marked *nævus* was present at birth is not improbable. I named mine "*nævus-lupus*," recognizing in that name its origin in congenital peculiarity and its assumption of infective and serpiginous qualities. I have no doubt that the disease is a near ally of what I have named *Lupus lymphaticus*, for in the latter, in addition to the lymph vesicles, &c., there are little tufts of dilated vessels just such as are seen here. In these cases, however, there is no lymphatic element, the changes being vascular only.* I had fortunately my drawing with me in Berlin, and had opportunities of showing it by the side of Dr. Lassar's model to Dr. Unna, Professor Kœbner, and Dr.

* The following extract from my note-book gives, perhaps, a more precise description of the conditions in Dr. Lassar's case:—"The back of the forearm and hand showed superficial red stains abruptly margined. The large patch, which was composed of conjoined smaller ones, consisted of ill-marked rings and half-circles. On the hand itself the changes were more superficial than in other parts, and exactly those presented in my own portrait. There were minute tufts of dilated capillaries arranged partly in rings and partly in dots. The condition extended to the very end of the thumb, becoming fainter and fainter as it advanced. It extended above the elbow to a certain height."

* Since the above was in type I have received from Dr. Wittrock (Dr. Lassar's assistant) the following details of this important case. It will be seen that they appear to connect it closely with true *Lupus Erythematosus*. The early age at which it began is, with the history, very remarkable.

"Charlotte Schmidt, aged three and a half years, was born perfectly healthy. Her parents were also healthy. The child suffered with difficult teething, and got sometimes convulsions during this time, but remained otherwise in good health. At the age of nine months, there appeared, on both cheeks at the same time, a few small red spots; at first a few spots only of the size of a very small pea, later on a larger number until the rash got the size of a florin on each cheek. The colour of these spots was a rather clear red; the skin between the spots also a diffuse red. A few weeks later the affection began on both ears, but did not spread much.—A whole year later the disease began on the arm. There appeared on the right upper arm large and diffuse spots of an intensive red. These spots spread during eight weeks from the humerus unto the dorsal part of the right hand. The mother is sure that a *nævus* never existed on the body of the child."

Payne, none of whom doubted as to the identity of the disease in the two cases. In Dr. Jamieson's case there was no history of congenital nævus, but the patient was young and the condition had begun in infancy, so that it is quite possible that some congenital vascular peculiarity had been present although not noticed. It is to be remembered, however, that the facts are precisely similar as regards Lupus lymphaticus. Some of the examples of the latter are in association with nævi, and others are not. All, however, begin in early life, and thus, as already said, suggest suspicion of congenital peculiarity of tissue.

I am not unaware that some writers, adopting what appear to my mind narrow and conventional definitions of the words, have objected to the name Lupus lymphaticus. It was therefore with interest that I observed that Dr. Lassar had quite independently used the term lupus for what I had called nævus-lupus. There is no doubt that in the one case the morbid process is that of a lymphangioma, and in the other of an angioma, but these names are those of pathological anatomy only, and do not comprise any reference to the clinical features of the malady. It is in the latter that the lupoid characters appear. It is a new conception of lymphangioma to be told that it may prove infective, spread by satellites, &c., for twenty years together, disorganize the affected skin and leave scars. These are the qualities of a lupoid affection. I have never taught that "Lupus lymphaticus" is the same thing as either lupus vulgaris or lupus erythematosus. It is undoubtedly very different from both, as they are very different from each other. They all, however, belong to one family.

Two models represented the newly observed disease to which the name Pityriasis rosea has been given. They afforded proof that the same name is applied to the same thing in Berlin as in London. Dr. Payne agreed with me that they were very fair representations of this curious malady. They showed patches on the chest which were congested and desquamating, and of which a very noteworthy feature was that none of them approached any well defined form of either oval or round. All were irregular in shape,

like islands with capes or promontories, or still more like so many amœbæ sending out their processes. All the patches were slightly desquamating, and there were a few blood-stained spots as if from scratching. Those who are acquainted with this curious malady will be aware that it presents features of resemblance to ringworm, to dry eczema, and to certain forms of secondary syphilitic eruptions. It is, however, quite distinct from all these, and presents the remarkable clinical feature that, after lasting a few weeks or a month or two, it usually disappears under any treatment or under none at all. Its chief importance is in reference to diagnosis, —that it may not be mistaken for something of a much more serious nature.

Under the name of *Acne Necrotica*, Dr. Lassar presented us with the face of a young adult man, which showed a symmetrical eruption covering the forehead, and occurring also on the nose and chin. From the nose it extended down the alæ, round the corner of the mouth, and thus as if by contagion advanced to the corner of the chin. The acne spots were small, and were for the most part discrete, and almost all of them presented minute sloughs in their centres. The intervening skin was scarcely at all inflamed. It seemed to be the same disease as that to which the name *acne varioliforme* has been given, and in the absence of clinical history, a suspicion as to syphilis naturally occurred.

There was also a good model of *xeroderma pigmentosum* or Kaposi's disease. It showed the face of a girl covered with pigment spots and stigmata. It is to be noted that some of the latter were on the probabium. The skin was evidently tight and in a condition of sclerodermia. The eyelids were covered with stigmata, and the eyelashes partly destroyed and in tufts. There was some ulceration on the alæ nasi and at the outer corners of the eyelids. The tightness of skin was a prominent feature.

A paper on Intussusception which I read in the Surgical Section was chiefly intended to elicit discussion and expressions of opinion and experience from others. In this, owing to the pressure of business, and with the exception of an interesting speech from Mr. Howard Marsh and some remarks

from Professor Czerny, of Heidelberg, it failed. My recommendations were a vigorous trial of intra-abdominal taxis in the first instance, and prompt resort to laparotomy if needed. I felt obliged to speak discouragingly of the operation in infants under one year, in whom the disease runs a very rapid course, and unless immediately relieved by taxis is almost invariably fatal. Mr. Marsh spoke more cheerfully as regards this group, recommending operation in very early periods, and pointing out that death was inevitable without it. He admitted that but very few were saved, but believed this result chiefly due to delay. Several of those present mentioned to me afterwards cases of most encouraging results from operation.

In the Section for Ophthalmology I had two short papers. The first was on a form of Choroiditis sometimes seen in cases of Osteitis Deformans. Sir James Paget and others have noticed that some subjects of this peculiar disease fail in sight, but I believe that my case is the first observation as to the precise changes which occur. The drawings which I exhibited were from an elderly gentleman, the subject of the disease in a most marked form, who had for years been partially blind. The regions of his yellow spots, and for a wide area around them, were symmetrically disorganized by choroiditis. He was also deaf. The choroiditis appeared to be arrested.

My second paper concerned a form of Choroiditis which has recently much interested me, in which, without any history of syphilis or any derangement of general health, a serpiginous and usually symmetrical disease is set up. It begins close to the temporal border of the disc, and spreads to the yellow spot. The margins of the patch are very abrupt, and sometimes show swelling or a condition of hæmorrhagic thrombosis. In its serpiginous qualities the choroiditis resembles a lupus of the skin, but it is usually quite symmetrical and may occur in healthy persons. The disease has, I believe, not hitherto been recognized.

Part of the morning of Sunday, Sept. 9th, was spent in the museum of the Pathological Institute. This museum is, I believe, almost wholly the collection of Virchow, and he still takes the keenest interest in adding to it. It is not one which a stranger can consult, for the specimens are not displayed or

catalogued. In this respect it differs notably from the collection formed by Rokitanski at Vienna, and from that of our own College of Surgeons. It is, however, full of most valuable material, and the professor is very obliging in facilitating the objects of those who wish to make private research. Fifteen years ago I was allowed to seek amongst its treasures for (amongst other things) the evidences which pathological anatomy can afford as to the characters and frequency of gout and rheumatism in Germany. On the present occasion my eldest son, who was with me in Berlin, had made application to be permitted to examine the specimens of syphilitic diseases of joints, of which the museum contains an exceptionally valuable series. The professor responded to his request by meeting him there and showing him the specimens. I made a third, and we were shown also many other objects of great interest. In the Congress Museum I had seen specimens of intestinal concretions, "Darmsteinen," which were simply so labelled and had no history. I wished to know whether biliary calculi ever formed the nuclei of these. Virchow said that he had no evidence in proof that biliary calculi ever grew bigger in the intestines. He had no specimen which showed any accretion of matters derived from the contents of the bowel. He showed me some very large biliary calculi which had been safely passed per anum. I had previously seen others with the same history in the Congress Museum. I had no opportunity for exact measurements, but I do not think that any exceeded the dimensions of those which were figured in the last number of the ARCHIVES.

Returning to the subject of "Darmsteinen," the professor showed us a large concretion removed from the bowel after death, in the middle of which was a plum-stone. The puzzle presented by such specimens is to tell why the nucleus itself did not readily pass, seeing that bodies far larger so frequently come away without inconvenience.* Probably these instances

* A country practitioner whom I knew when young, used when consulted by anxious mothers whose children had swallowed halfpence, &c., to content himself with the time-honoured joke, "Was it good money, ma'am?" "Oh, yes!" "Then you may be sure it will pass." Yet that this is not

of retention and accretion are from cases in which pouches or strictures or other mechanical causes of impediment existed. We were shown, however, two other specimens bearing upon this topic which were of very special interest. They were much alike, and in each instance consisted of a concretion of a reddish colour, and about as big as the last joint of a large thumb. In each instance the concretion was removed from the duodenum of a man. Virchow told us that the first had caused much speculation and bewilderment as to its nature and mode of origin. When, however, the second case occurred, it was then noticed that both the patients were artificers in the same occupation, that of painters. On inquiry the fact came out that they had been in the habit of drinking varnish, a solution of shell-lac in spirits of wine. The concretion in each represented the shell-lac with additions. Why should concretions so arising remain in the duodenum, and not pass lower down and escape?

German museums of pathology contain many specimens of a class which ours in England are not rich in. I refer to those illustrating diseases artificially produced. Virchow was particularly interested in demonstrating to me that the administration of phosphorus to animals might produce diseases of the bones which were not distinguishable from the results of syphilis. He showed a large series of specimens exhibiting caries and necrosis of various bones. He insisted on the point that a chemical poison produced similar conditions to those which in the case of syphilis are attributed to a vitalized one. I was interested not only in this fact, but also in the fulness of the proof afforded that the internal administration of phosphorus could cause bone disease, since it has perhaps been too much the habit to assume that the necrosis of the jaws is the result of direct action of the vapours on carious teeth or exposed alveolus. I published some years quite universally the case is proved by certain exceptional specimens in our museums.

The *Canadian Practitioner* for the present month contains the record of a case in which a boy of 7 retained a cent, which he had swallowed, for ten months, and finally voided it. The coin measured an inch and an eighth across. It had not given much trouble.

ago* the case of a lady who had extensive necrosis of the lower jaw from very prolonged administration of phosphorus pills, and it was, I believe, received with a certain amount of incredulity.

We were also shown bones from two infants, twins, in which those of one showed extensive evidences of inherited syphilis, and those of the other none whatever. I have often insisted upon the importance of investigating the facts as to twins in reference to inherited syphilis, and also other heritable taints. It is by no means improbable that one foetus may wholly escape and its brother suffer, and this fact if proved would be very important in helping our belief as to what takes place in transmission. I have myself published cases in which one twin appeared to escape, and the specimens in Virchow's collection afford further and very valuable proof that such apparent escape may be supported by the evidence of the autopsy. Unfortunately for those who, with myself, are believers in the possible latency of the taint, although still in reality present, they by no means prove the whole theorem (that of two conceptions occurring together, one may be attended by communication of the taint and the other not).

The usefulness of these meetings is by no means confined to the addresses or sectional meetings or museum-exhibitions. The Scotch servant-girl when enjoined by her mistress to come straight home from church, positively declined to promise, remarking that she "would not give the crack i' the kirkyard for a' the sermon." So often with us the set discourse in the Section-room is less pleasant, and even it may be less instructive, than the chance conversation before or after the meeting. Neither at Birmingham nor Berlin did we shun "the crack i' the kirkyard." At Birmingham half the dermatologists of Great Britain and Ireland were present, and the Continent and the United States were well represented. Opinions were interchanged freely, and private debates took place which would not be recorded in the Journals. At Berlin nearly every one was there, and you might seek a confidential opinion upon any favourite topic from the chief authority on it, whether in Europe, or America, or the Colonies.

* See Transactions of the Clinical Society.

In Birmingham I had been assured by a local authority that syphilis there was a very mild disease. The severe cases, which were very rare were, he thought, always contracted somewhere else. At Berlin, an authority from Australia of great pathological experience mentioned to me quite spontaneously the same fact. "We never see in Melbourne," he said, "the severe forms which are described in English books. Nothing is less common than for us to find disclosures of syphilis in the *post-mortem* room. Of brain syphilis we have no specimens." These statements would, I believe, be echoed by observers in many other places. Every one thinks that syphilis is more rife and more severe in other places than where he chances to practise. The explanation is I think to be found not in one direction, but rather in two. In the first place our recent literature has given, by the record of rare cases as if they were common, a much exaggerated picture of the disease as a whole; and in the second, the last twenty years have really witnessed, by the introduction of better methods of treatment, a very definite amelioration of the malady in all its several stages. I do not for a moment believe that Birmingham syphilis is a milder disease than the London type.

At Berlin, as I have said, almost all the European authorities on Leprosy were present. Many were the opportunities for discussion which were afforded. In the Gardens at Potsdam three of us agreed that the topic should there be tabooed, but a fourth joining the group and in hot zeal propounding a much-debated question, our good resolutions vanished, and during the next twenty minutes we had travelled over much ground. At the Potsdam Station, on our return journey, I was accosted by my quondam London friend and associate, Dr. Bäumler, now and for long the distinguished Professor of Medicine at Breslau. He wished to speak to me on a subject in which I should, he felt sure, take interest—the occurrence of prolonged febrile disease in association with a persisting eruption like that of erythema nodosum. I found that he knew only of a paper of mine which was written many years ago, and was not referring to the two most unusual cases which I have recently recorded in the ARCHIVES. These he had not read. I found

on further conversation that Dr. Bäumlér had come across cases not unlike these latter, and that he had collected and was about to publish some others which had been noted by other observers. When I published mine, I admitted my ignorance of any literature on the subject, and solicited, but without success, any information on this point from my readers. Dr. Bäumlér has been more fortunate, or more industrious, and if the cases which he is about to record should prove to be, as I believe, of the same kind as my own, we shall, I think, be enabled to add a new and valuable chapter to our treatises on Medicine. The cases referred to are usually in the first instance taken for typhoid fever, but they become protracted, and are attended by the development of nodosities in the skin and cellular tissue much like those of erythema nodosum. "Typhoid fever" was the diagnosis confidently given by an eminent physician in one of my cases, and Dr. Bäumlér told me that exactly the same had happened in one of his. I shall await with impatience the publication of his paper, for as yet I know only what he told me on the steps of the Berliner-Potsdam Bahnhof.

Amongst other bits of surgical gossip I was told by a fellow-visitor to Potsdam that the paralysis of the left arm from which the German Emperor suffers is of the same nature as that in the child whose case is published at page 64 of the ARCHIVES. I cannot vouch for the truth of this, but the history makes it not improbable. If the fact be so, they are both examples of an exceedingly rare accident.

After the Congress was over, my son and I returned *viâ* Hamburg, in order to see the New Hospital there and to visit Dr. Unna and his private institution. We had a day in Hamburg, and were much pleased and interested by what we were shown in the two institutions named. The New Hospital at Hamburg was only finished within the last two years, and is perhaps the best example of elaborate arrangements for the restoration of health which yet exists. It has apparently been designed almost regardless of expense, and reflects great credit on the city which has built it. It is a mile out of Hamburg, and may be described not as a village hospital, since such a term might mislead, but rather as a

hospital village. Dare I say that there are nearly a hundred detached erections? I forget whether I am a little over or a little under the mark. Attached to the village is what might, by its tall chimney, &c., be mistaken for a factory for the supply of accidents, but which is really the laundry, &c., of the establishment. The great number of separate buildings has been necessitated by the desire to prevent contagion and by the wish to avoid many storeys. Most of the pavilions are of one storey only. There is a detached ward, or rather series of wards, for diphtheria and another for palmar abscesses, and of course one for syphilis, and perhaps less of course one for delirium tremens. Curiously when we were there the syphilis block had no patients, but I am sorry to record that the delirium tremens ward was full. The absence of syphilis is to some extent to be explained by the existence of another hospital for it in the city.

The arrangements for securing asepticism are in all departments admirably complete. The whole institution is under the able and zealous surgical care of Herr Schede, who on the morning of our visit conducted a large party from the Congress over it. It is a misfortune that there is no medical school attached. There is not a place in the world to which the expression "walking the hospital" would be more appropriate, nor than Herr Schede many teachers under whom students would be more likely to profit.

We witnessed an excision of one half of a large bronchocele by Herr Schede, which was done very carefully and very skilfully. He told me that he had done a considerable number of these cases, and, so I understood, some complete extirpations, and that he had not as yet in any case witnessed any tendency to cachexia strumiprava or myxœdema. We were shown in the wards a gentleman who was doing very well on the eighth day after an excision of the pylorus. We saw also an instance of excellent motion at the hip joint, with ability to walk on the limb and no slipping up and down at the joint, after a modified resection of the hip. In the same patient and on the same day the wrist of one hand had been excised, with excellent results. Such operations may be taken as proof that the surgeon performing them has the fullest con-

fidence in his antiseptic precautions. Herr Schede told me that stone is not common in Hamburg, and gout he thought very rare. Diphtheria is common, and tracheotomy for it a frequent operation and very fairly successful. Most of the patients in this hospital pay something. Even the well-to-do are allowed its advantages if willing to pay according to their means. The subject of the pylorus case just mentioned was, as said, a gentleman of means, and had a separate and very comfortable room.

Dr. Unna's establishment is a private one and wholly under his own management. It is for the treatment of intractable skin diseases. His patients, as is not uncommon on the Continent, do not appear to make any difficulties as to being seen by visitors, and as a matter of fact Dr. Unna does a good deal of teaching. He has a number of lepers under treatment at present, and believes that he is doing them great good. These and a number of other very interesting cases were shown to us. Here again we had the pleasure of meeting a very considerable section of the London Dermatological Society, like ourselves on their way home. We passed two hours very instructively and pleasantly.

SARCOMATOUS ERUPTION SIMULATING SYPHILIS.

Multiple Sarcomata of the Skin developed with such rapidity and abundance that the case was at first supposed to be a syphilitic eruption—Death in about two months from the outset.

THE subject of the case was a young married man of dark complexion. He had always previously enjoyed fairly good health, but I was told that he habitually looked pale and was not very robust. The eruption for which I was asked to see him had made its appearance for the first time only five weeks before. He was at the time staying at Dartmouth with his wife for his usual holiday, and was not feeling in any way ill. He was bathing every day in the sea, and on one occasion after his bath noticed some spots on the skin over the region of the liver. As he did not feel ill he did not think much of them, and continued his usual mode of life. A fortnight later he returned to town and showed the patches to his medical adviser. Dr. — describes them as having been flattish smooth wheals or papules, which he diagnosed as “lichen planus.” At this date there was a threatening of other spots on the abdomen and back, and, during the next fortnight, these regions, as well as the face and scalp, became covered. A little later the upper and lower extremities were also spotted over with eruption, but of a somewhat different character from that on the trunk. In the meantime the lymphatic glands in various regions—namely, neck, axillæ, groins, &c.—had taken on enlargement, and had become very hard. At the time that Mr. —’s eruption began to appear he was not taking any drugs, nor using any article of diet which could be suspected as likely to cause it, and he had never in previous life had any kind of eruption. Nor did he take any iodide or bromide during the early stages of the

development of the eruption. He had been seen by two eminent dermatologists before I was consulted, and by one of these, under a confident diagnosis of syphilis, mercury had been given. He had taken mercury and a little iodide for about ten days before I saw him, and his gums had been slightly touched. I believe that the diagnosis of syphilis had been based in part on the general enlargement of the lymphatic glands, as well as on certain suspicious features in the eruption itself. It is right to state that Mr. ——— most absolutely denied having ever suffered from any form of primary venereal disease, or having been exposed to the risk of it.

The following description applies to his state at the date of my visit during the seventh week of his eruption. He was at this time confined to bed, and having had very bad nights in consequence of the pain in his back, which recurred every night. He was feeling somewhat weak, but was not much emaciated, nor did he look seriously ill.

Description of the eruption, October 25, 1888 :—

The eruption consists of tuberculous nodules developed apparently in the deeper layers of the skin. They are closely adherent to the skin and involve its entire substance, but they do not show anywhere the slightest tendency to ulcerate or to form pustules. They vary in size from shots to small halves of marbles. Many of them are oval rather than round, and in many places, owing to confluence, long irregular streaks have been formed. Over the larger of them the hairs of the part may be seen to grow without any interference or inflammation. In very few instances is the skin movable over a tumour. The parts most severely affected are the middle lines of the chest, abdomen, and back, and on these the spots are placed so closely that the whole skin is covered. Towards the sides of the abdomen and chest, the eruption is less abundant. The face is slightly involved and the patches are here less marked, consisting only of ill-defined lines of induration or wheals, not unlike those seen in true leprosy. Indeed his face has a decided approach to the "leonine aspect" of the latter disease. His scalp is covered over with ill-defined ridges and papules

which are very perceptible to the touch, but less so to the eye. In the conjunctiva of one eye, close to the sclerotic



region, there is a little dusky patch like what is often seen in leprosy. The eruption on the arms is not very plentiful, and

does not differ materially in character from that which has been described on the trunk. On the lower extremities, however, some very noteworthy differences are to be observed. On these parts the spots, which are mostly not larger than split-peas, are very few of them raised, and they are all of them so deeply congested as to be almost black. The appearance at first sight is almost like that of hæmorrhagic purpura; but on careful inspection there is clearly no extravasation. The venules composing the patches cannot be emptied by pressure, and a slight amount of thickening around them is clearly perceptible to the touch. On the upper extremities the spots are fewer on the forearms than on the arms, and there are none on the hands; and on the lower extremities they are fewer on the legs than the thighs, and there are none on the feet. No deviations from bilateral symmetry are to be observed in the arrangement of the eruption. The patches were everywhere, especially on the chest and abdomen, more or less tender on pressure. The colour of those on the legs has been described. Those on other parts are of a dull olive or greenish purple tint. Their colour is everywhere in part due to congestion, and can be modified, but by no means wholly removed, by pressure.

Glandular enlargement.—The enlargement of the glands was very definite; in the neck all the concatenate glands were involved, and to such a degree as to bulge on each side in masses which were quite visible. The individual glands could be easily isolated, and they were very hard. Similar gland masses were present in both armpits and both groins, and everywhere the glands were of great hardness, more nearly approaching the conditions of malignant affections than any other state. No soreness of the throat had been noticed, but on examining it I found on the right tonsil a kidney-shaped ulcer exactly like those with which we are familiar in syphilis, and a similar condition appeared to be beginning on the other side; he was in a condition of slight ptyalism, and it is possible that these conditions were due to mercury.

In attempting a diagnosis of this very unusual case, I first

put aside the suspicion of its being a drug rash, for the reasons that no drug had been given, that the eruption had not developed symmetrically in the first instance, that it had been steadily aggressive, and that the lymphatic glands were involved. On almost parallel grounds, I entirely rejected all suspicion of syphilis. In particular I have never seen in syphilis the slightest approach to such gland disease as was present in this case. That the eruption did not resemble psoriasis, lichen, or any named form of eruption, is sufficiently obvious. It was far too acute for leprosy, and above all we have the rapid and remarkable enlargement of the lymphatic glands as a feature which placed it at a distance from every known form of skin disease. The history of its commencement by a local group of spots on one side of the trunk seemed to imply that whether it was malignant new growth or some form of inflammatory action, it was at any rate infective: by which term I mean that the original spots produced material which, multiplying in the blood, in time became the germs of other patches. With this theory the implication of the lymphatic glands of course fitted well. We had then to choose between the hypothesis of some new type of inflammatory action and that of a malignant new growth. The balance of evidence seemed to me decidedly in favour of the latter suggestion, notwithstanding the remarkably rapid development of the eruption (only seven weeks), its extent, and its peculiarities. My suspicion in this direction received some support from the information given me by the patient's father that his wife had died of cancer (in the abdomen). Her death did not occur till twenty years after the birth of our patient, her son.

I was allowed to excise one nodule for microscopic examination. The portion removed consisted of an ovoid lump about the size of a hazel-nut, and included some of the subcutaneous fat. The latter was of a deep yellow colour and looked jaundiced. On section of the lump it was seen to consist of an infiltration into the true skin of at least a quarter of an inch in thickness, which presented a glistening and moist surface, from which juice could easily be scraped. It was inseparably united to the epidermal layers above, and pre-

sented no definite line of limitation below. Scrapings of its juice showed cell elements in great abundance, mostly small, round, dimly granular cells, with nuclei not very conspicuous. Microscopic sections were declared by experts to be characteristic of round-celled sarcoma.

On October 30, 1888, Dr. B——, Mr. M. B——, and myself met in consultation. Only a week had elapsed since my first visit, but the advance of the disease had been most rapid. The whole of the scalp was now infiltrated and hard, and no separate tumours were to be found. All down the middle of the chest and middle of the back, in like manner tubers had coalesced, and the larger ones having somewhat flattened, a dense thick plate or cuirass was in process of formation. Where the tubercles remained discrete they had increased in size and thickness. Those on his legs especially had become thicker. Most of these at the time of my first visit had been flat, so that they were supposed to resemble purpura, and it needed careful examination to appreciate any thickening; but they now consisted of little tubercles, more or less conical, with pale centres and a dark purple area at their base. The pale centre was evidently due to growth upwards in the middle of the patch, which had compressed and displaced the vessels. The little growth on the sclerotic of the left eye was three times as large as it had been a week ago. It was quite without any inflammatory congestion, and looked as if a portion of liver, half the size of a pea, had been placed under the conjunctiva. There were slight indications of the beginning of two or three similar growths on the other eye.

The most serious feature denoting aggression of the disease was, however, a rapid failure in strength. Mr. C—— looked pale and exhausted and felt faint on exertion, and his pulse was very weak. On the former occasion he had been able to get out of bed and walk about the room easily.

The severe pain which he had had every night in his back was probably one of the chief causes of his exhaustion. There was, however, a degree of breathlessness which made some of us suspect that some intra-thoracic growth was in process of formation. The most probable explanation of the

pain in the back seemed to be the existence of a growth in connexion with the bones, and during the last few days there had been a numbness of the thumb, index and middle finger of the left hand, which probably implied a growth in connexion with the nerves. The patient's state at this visit was such as to make us think that he would not live more than a week or two. Yet the disease from its onset had been present only six weeks.

In our search for the primary growth in this case careful inquiry was made as to any symptoms suspicious of any intestinal or thoracic lesion. None, however, could be detected. Nor on the most careful search could any congenital nævus or mole be discovered on the skin. On the testimony of several of Mr. C——'s friends, he had been looking decidedly ill before he went to the seaside; but he would not himself admit that he had felt so.

In reference to the precise nature of the patches on his legs which had been called purpura, I do not feel any doubt that they were all of them the consequences of local infection. It would appear that on these depending parts, a very early result of infection was thrombosis of the venous capillaries, or their extreme turgescence with blood that was almost black. On careful examination with magnifying power I am sure that there was no real extravasation, and also that there did exist evidences of plugged blood-vessels. It is to be understood that these patches were most of them round, that they began as mere dots and then enlarged to the size of threepenny-bits, the enlargement in extent being accompanied by an increase of thickness in the middle which has been already described.

Those on the trunk differed from those on the legs, I believe, only in colour. The colour varied greatly on different parts. Thus the patches on the face were pale, or of a bluish or greenish tint. Those on the eye were exactly like liver. Those on the trunk were of a dull pinkish or brown tint, and those on the legs were as dark as a ripe blackberry.

On the theory, which is probably a correct one, that the skin lesions were secondary to some large growth existing within the trunk, it is still difficult to explain the remarkably

sudden outburst of the affection, as well as the absolute latency of the parent tumour.

Our patient died somewhat unexpectedly about two weeks after the last note. His death was preceded by several days of intense pain, chiefly in the back. No post-mortem was obtained.

ON CERTAIN DISEASES OF THE LIPS.

It is a matter of common observation that the state of the prolabium is often a good test of health. In many conditions of defective tone, the epithelium of this part becomes dry and may crack and peel. One of the most marked examples of this condition which I have ever seen, occurred in a lady named B——, aged about 30, who was sent to me on account of it, by Dr. Aveling. She had long been under Dr. Aveling's care, and had suffered much from ovarian disturbance. She was greatly out of tone, and was fatigued by the slightest exertion. Her lower lip was not merely cracked and dry, but was liable to have large crusts form on it. These crusts sometimes covered one half of the surface, and were thick and conspicuous. After remaining on a week or two they would loosen at their edges and become detached, leaving an excoriated surface underneath. In the first instance, Miss B—— consulted me in 1881 specially about her lip, and I prescribed for her an ointment and gave arsenic. She came to me again in 1884, and on this occasion on account of acne on the cheeks. It was of the pustulo-erythematous form, most of the pustules being abortive, and there being no comedones. No doubt the acne was due to the same cause as the state of the lips. She was pale, wan, and feeble. Her lip had never got well, but she told me that while she had continued the arsenic, it, as well as her general health, was much better. She had not taken it recently, and the lip was now as bad as ever.

Another excellent example of the same most troublesome condition occurred in the person of a Miss P——, the daughter of a country solicitor. She was 19 years of age, a brunette, tall

and thin. She was exactly like her mother, and in the latter I noticed that the lower prolabium was liable to peel, although it was not definitely diseased. In Miss P—— the disease had commenced about six months before I saw her, and it now occupied the whole of the lower lip, and was threatening the upper one. The lower lip was slightly swollen and everted, and covered with a dryish crust, which peeled off in thick flakes, leaving the surface cracked and sore. The crusts usually cleared off about once in eight or nine days, and during the intervals they could not be got away without causing cracks and soreness. As soon as they had fallen fresh formation began to take place, and the height of the disfigurement was again reached at the end of a week. Miss G—— had had a good deal of treatment before I saw her, had taken arsenic, and used a variety of applications. When she came to me she had just returned from a journey on the Continent, which had improved her health, but left her lip as bad or worse than before. It could not be said that she was out of health, but she was not very robust. She had never had any other form of skin disease. I advised a long residence at the sea-side, and prescribed arsenic and a tar wash. She had been liable for some time before the lip-affection to little round ulcers on the mucous membrane on the inside of the lip. Of these I saw one during the treatment. It was probably herpetic, but it lasted more than a week. It might possibly have been caused by the arsenic.

The case of Mrs. P—— is of some interest as another example of this disease. She was a delicate lady of thin skin. She was the mother of several children, and no special illness had preceded her troublesome local malady. She was, however, decidedly in feeble health. When the lips first inflamed she was living with her husband in India, at Bangalore.

She had suffered from peeling of the prolabium for about a year when I saw her. It was not a severe case, as there was little or no moist exudation; but as her lips were constantly covered with thick opaque flakes, it caused her great annoyance. The flakes would crack transversely, and were detached

about once a week or ten days, when the process of re-formation would again commence.

The influence of climate had not been very marked, and it will be seen that the affection commenced when she was living in a warm air.

Mrs. P——, of New York, consulted me on the kind suggestion of Dr. Besnier of Paris. She was a thin, delicate lady of about 50, who for the last three or four years had suffered very severely from dyspepsia. The diagnosis of a dilated stomach had been given, and she had been subjected to great restrictions in diet. During the last two years she had lost flesh very considerably. It was not, however, for her general health that she came to me, but on account of chronic inflammation of the prolabium of the lower lip. The lip was in exactly the same condition as that described in the three previous cases; that is, it was slightly swollen, and the whole of its red part was covered by a thin opaque crust. I was told that this crust peeled off at its edges, once every week or ten days, leaving the lip looking at first almost well, but with the certainty that in a day or two it would crust over again. The crust did not extend quite to the angles of the mouth. It did not when I saw Mrs. P—— affect the upper lip, but she told me that it had formerly done so to a slight extent. Mrs. P—— had already had the advice of many specialists and physicians, in New York, Paris, and London, but she was rather losing ground in health, whilst her lip remained much as it had been. It was a great trouble to her, both on account of the disfigurement and its soreness. She had no skin disease elsewhere, nor had she ever had sore lips until about a year ago. She told me that she was always better when at sea. I advised that she should try a long voyage, that she should endeavour to take a more liberal diet with some wine, and that the lip should be painted once in a fortnight with a strong ethereal solution of nitrate of silver.

I once saw a very severe case of this disease in a strumous and cachectic lad of about 20. The prolabium of both upper and lower lip was ulcerated and covered with crusts. But the disease was strictly limited to that part. It had been present,

I believe, for some years, and had probably been much neglected. He came under my observation on account of an ulcer on the cornea. He had no other skin disease. He was not my patient, and I never saw him again. The case is an illustration of the intractability of this disease, and its association with feeble state of health.

With this case I will conclude my series of illustrations of chronic inflammation of the prolabium. The four which I have given are clearly all of the same type. They exemplify a disease which becomes conspicuous only by exaggeration. In a great many persons the prolabium is apt to dry and peel more or less. It is by no means accorded to every one to enjoy the condition of constantly soft and healthy lips. It is only, however, in a few that the tendency to peel amounts to a really troublesome malady. The cases given may be held to well illustrate the conditions usually assumed when it does so. The crusts separate once every ten days or a fortnight, leaving the surface red and raw. The process of re-formation soon commences again, and in another ten days exfoliation again commences. Whether the process is more nearly allied to one of *seborrhœa* or of *eczema*, or whether it should be affiliated to neither, is a matter as yet in doubt. That it is not usually met with in association with any disease of the skin in other parts I feel tolerably certain. I have seen many other cases than those above reported, and never saw peeling lips in association either with *psoriasis* or with general *eczema*.

Unfortunately the subjects of this troublesome malady are usually young women, to whom it is especially annoying. That it is connected in some way with defective tone, there can I think be little doubt. Those who suffer from it only in slight degrees and it may be only occasionally, will often recognize in the state of their lips a good index of general health. It comes also to some extent in connection with exposure to cold and wind. But making all allowance for these two classes of influence, the disease, when once it has got possession, appears to be able to maintain it in a certain sense in its own right. It is not cured by warm weather, nor after the patient has been restored to what appears to be an excellent state of

health. This was very notably the case in the second of my cases just narrated, in that the young lady appeared to be quite well, and through various changes of season and of climate the condition still persisted. As regards treatment, I should incline to regard residence at a mild seaside place for a very long period as by far the most efficient. Tonics and arsenic should be given internally. Externally I have tried a great variety of applications. An emollient lip-salve should of course be most perseveringly employed, not merely once, but many times in the day. In the more obstinate cases I think that benefit has been obtained by painting the denuded prolabium once in ten days with a strong ætherial solution of nitrate of silver.

A remarkable case of Bleeding Fissures in the Lips—Hysteria and suspected malingering—(Abandonment of this hypothesis).

The case with which I shall conclude this paper is one not exactly of the same class as the above. The affection was of ten times the severity attained by them. It presented also distinctive features in the tendency to deep fissures and to attacks of hæmorrhage.

The following are some imperfect notes which I wrote out some years ago.

The most extraordinary condition of the lip which I ever saw was in a girl who was brought to me by Dr. Barnes, and in whom a series of deep gashes divided the prolabium into four or five portions. These easily bled, and sometimes profusely. I saw the patient hurriedly, and only once. If my memory serves me, it affected both the upper and lower lips, but the latter chiefly. She was a girl of 14 or 15 years of age, and the deformity produced was so extraordinary that I suspected at the time that it must have been produced by artificial means. On thinking the case over since, however, there appears no good ground for this hypothesis. It was remarkable that the lip was not materially inflamed, but simply cut in deep-gashes.

I saw this young lady only once, but some years afterwards Dr. Barnes was kind enough to draw my attention to the fact that further particulars of it had been published by Dr. White,

of Retford, in *The Medical Press*. I copy an abstract of Dr. White's statements:—"The patient was a little girl aged 14, the child of people in a good position of life. When first seen there were five deep fissures in the lip, from which the blood was flowing freely. The history was that they began as abrasions. It was impossible to stop bleeding except by direct pressure. At first constant, it afterwards became periodic, appearing every two or four weeks, and with other symptoms pointing to connexion with attempted menstrual periods which were not regularly established, and was very scanty when it did appear. Dr. White very carefully examined the blood from the lip, and said that it differed from ordinary blood both in smell and in microscopical character, and that it strongly resembled menstrual discharge. A number of consultations had been held with leading London physicians and surgeons, as the bleeding persisted for months and the patient's life was threatened. There were as many opinions as men, no two opinions being alike. Every possible measure was adopted to improve the patient's general health and to establish the menstrual periods. Some regarded the case as 'lip-hæmorrhoid,' others as 'severe ulceration of the lip;' yet others who regarded the case as one of self-inflicted wounds, and the mischief perpetuated by self-inflicted irritation to the bleeding points. Syphilis was suspected, but denied, apparently frankly so. The girl's father was a thoroughly sensible man with no nonsense about him. On the hint of self-infliction of the wounds being given, he set himself to watch his daughter closely, but thought there was not the slightest evidence to support the supposition. Finally Dr. White had the patient to his own house, chloroformed her and cauterized the fissures deeply with nitric acid, with the satisfactory result that in a week's time they were healed and the bleeding arrested. After the operation the girl had a very high temperature, and hysterical tetanus. The present condition of the lip shows only slight scars where the fissures had been. Dr. White notices that at the time for menstrual periods to appear the lip becomes deeply congested, as if the bleeding would burst forth again. Since the lip has been healed the menstrual periods have appeared regularly. There

is no denying the hysterical tendencies, as since the lip has healed there has been an attack of hysterical paraplegia, and immediately after the operation there was the attack of hysterical tetanus; but in spite of all this, Dr. White does not believe in self-infliction of the wounds, and he does believe in the bleeding having been vicarious to ordinary menstruation."

It will be seen that the case has striking features of similarity to one which I reported in the ARCHIVES a few months ago, in which a young lady had deep bleeding fissures in the palms and soles. She also was certainly hysterical in a high degree, but it seemed almost beyond possibility that she could have voluntarily produced the conditions which were present.

If any of my readers can give information as to the present condition of Dr. Barnes' patient, both he and I would be very glad to receive it.

I have failed to find Dr. White's address.

NOTES ON CANCER AND CANCEROUS PROCESSES.

THE propositions in reference to cancer which I am chiefly concerned to maintain, are—*First*, that it is a modification of chronic inflammation, and that the same laws which are applicable to the one are, for the most part, applicable to the other. *Second*, that it is under the influence firstly of inherited tendency and secondly of senility, that processes inflammatory in their outset tend to pass into those of cancer. *Third*, that cancerous processes are in their initiation local, and that the disease becomes constitutional by infection by elements derived from the primary growth.

In connection with the pathological doctrines just indicated, certain groups of rare cases in which cancer occurs in some sense as a complication of other forms of disease become of great interest. Thus, in Kaposi's disease we have first freckles, then ulcerations with granulation growth, and lastly a form of epithelial cancer. In granuloma fungoides, or in the various maladies which are put together under that name, we have an early stage sometimes not distinguishable from Eczema, whilst the later ones are undoubtedly malignant. The affections which it is the custom now to class as sarcoma of the skin, are some of them not easily distinguishable in the first, nor possibly even in any, stage from forms of chronic inflammation. The general bearing of such facts seems to be strongly in favour of the belief that, given certain individual proclivities, inflammation may slide into cancer. We may note, in passing, that when it does so, it is usually under the influence of approaching senility.

On Lupus-Cancer.

I purpose on the present occasion to record a few facts in reference to the tendency of Lupus to take on malignant action. There is nothing novel in the assertion that it

PLATE XXI.

LUPUS-CANCER.

THIS portrait shows the occurrence of epithelial cancer in the scar of lupus. The patient was a woman aged fifty-one, who had suffered from lupus of the face for about thirty years. In the scar of the lupus on the upper lip malignant ulceration had occurred about a year before I saw her. I excised the lip in October, 1873, making a free incision into the cheek in order to bring the parts together without tension. It healed soundly, but within six months another patch of malignant ulceration developed in the scar of the cheek at some distance from the original one. Chloride of zinc was now applied, but after a short time she declined further treatment. I believe that she died of the disease within a year of the commencement of the cancer.

I have seen several cases like this in which cancer attacked the scar left by lupus, and in all it proved rapidly aggressive. The microscope showed only the usual conditions of epithelial cancer, but the disease conformed to the type of rodent cancer in this, that it did not produce any disease of glands. In rapidity of progress it was, however, in marked contrast with what is usual in rodent cancer, destroying the parts widely and deeply.

See page 124.



occasionally does so.* Many observers have noted the fact and recorded examples of it. The observations which have been made respecting it have been tolerably uniform. It would appear that the change of process usually takes place late in the case. The lupus patch has probably been present many years before it takes on cancer. In other words, the patient has made definite advances towards senility. The cancerous action usually begins at the edge of the lupus patch, and in a part which was ulcerated and granulating. When once set going the cancerous action is somewhat rapid. It develops quickly a large sprouting mass, and it is remarkably resistant of all treatment. If destroyed by escharotics it sprouts again, and if excised, however freely, it is not long before a new growth demands fresh treatment. Such, at least, has been my own experience of what we may suitably call Lupus-cancer. It is, no doubt, a variety of epithelial—in this all those who have made microscopic investigation agree—but it is far more rapid in its spreading than is that form of epithelial, the rodent ulcer, which usually attacks the face. Whether it has any tendency to infect the lymphatic glands I do not know for certain. The cases which I have myself observed have been only few in number, and have ended fatally by local extension without, so far as I am aware, any implication of the glands. I have seen fragments of possibly near a dozen examples, but of only two am I able to recall the particulars in which I traced the case to the end. Nor in either of these two did I really see the patient myself during the last few months of life. These circumstances make it more difficult to speak with confidence as to gland implication than might have otherwise been the case. I think, however, that we may safely assume that although so different from “Rodent” in its rapidity and in the tendency to fungate, Lupus-cancer yet conforms to the rule so all but invariable in rodent of not causing gland disease. In the tendency to produce a prominent fungating mass it resembles what we see in Kaposi's disease. In the latter, however, I believe that there

* Royer, Devergne, Bardleben, O. Weber, Hebra, Kaposi, and Volkmann have all published examples of it.

is a far less degree of malignancy, the growth not passing deeply and being readily cured by local measures. If the reader will compare the portrait which I have given (Plate XXI.) with those which I copy from Bayha (Plate LXII.), and those of the latter one with another, he will see that what I have asserted as to tendency to fungate is fully borne out.

In reference to the production of carcinoma in the scars of lupus, it is of great interest to note that Dr. Sangster and other observers have recorded that even in cases where nothing like cancer was present, the malpighian layer yet showed a remarkable tendency to send processes deeply into the diseased corium. Such facts favour the opinion above expressed that processes of common inflammation may be attended by a simulation of those of cancer, and with probably in the end a decided tendency to its reality. I do not think that we shall be right if we simply regard Lupus-cancer as cancer of scar-tissue. To some extent it may be so, but not I think usually. Cancerous processes taking origin in a healthy scar, such for instance as that of a burn, are, I believe, often very slow in progress. They run a course very different from that of Lupus-cancer, which is usually acutely malignant. Mr. Cæsar Hawkins, who first noted the peculiarities of cancer of cicatrix, held that usually the glands did not become affected. It is not improbable that we must recognize some varieties in Lupus-cancer, these being determined by the precise tissue in which the process begins. In some it begins in parts still affected by lupus-growth, in others in tissue more or less closely approaching to sound scar, and in yet others it does not begin either in scar or in lupus tissue, but only in parts adjacent to them. The facts illustrating the latter are, I must admit, only few, but they are sufficient to suggest that there is a bond of connection between lupus and cancer more close than would be indicated by regarding all cancer occurring in such association as simply cancer of scar.

I will record briefly the notes of a few cases with exceptional features.

Lupus of old standing—Rodent Ulcer in the same side, but not continuous.

A lady of about 45, Miss —, whom I had long had under observation for a patch of common lupus in her left cheek, had an ulcer form in the healthy skin beneath the inner angle of the eye on the same side. This ulcer was a well-characterized rodent or superficial form of epithelial cancer. There was a considerable width of healthy skin between it and the lupus patch.

*Lupus-Cancer in an old-standing Lupus Patch on the face—
Epithelial Cancer near anus.*

In another instance lupus-cancer attacked the lupus patch, and simultaneously a cancer of another type developed on a distant part. This case is one of the most important examples of cancer following lupus which has come under my observation. Mr. K—, of Farnham, was about 56 years of age, and had suffered for upwards of thirty years from lupus of his face when he came under my treatment. He then had a fungating growth of cancer in the middle of a lupus patch on his left cheek. I destroyed this with chloride of zinc paste several times, but only with temporary success. At length, the bone having become implicated, I did a severe operation, cutting away all the anterior part of the upper jaw, and at the same time removing soft parts most freely. At the time that this operation was performed he showed me for the first time a growth of epithelial cancer on the skin between the coccyx and the anus. It had the characters of rodent ulcer, and had been present, he said, more than a year. Mr. K— died about nine months after my last operation with a return of the growth on the face. In him, as in many other patients, we witness the influence of senility in disposing towards cancer.

Lupus followed by Rodent Ulcer (Cancer).

A gentleman, aged 34, was sent to me who had been for ten years under treatment for lupus on his right cheek. It had been repeatedly scraped and cauterised. The lupus had remained a single patch in the middle of the cheek. The

final condition, and that for which he came to me, was a scar with characteristic semi-transparent nodules and crescentic rolls of rodent ulcer. There was no family history of either consumption or cancer.*

*Epithelial Cancer in the Scar of Lupus-erythematosus—Excision
—Return near, but not in the scar.*

A young woman who was the subject of Lupus-erythematosus came under my care at the London Hospital in 1882, with a hard-edged ulcer on the left temple which had developed on the lupus patch. It was clearly malignant, and Mr. Waren Tay was kind enough to excise it for me. It healed soundly, and when the patient was next seen about two years later (February, 1884), the scar remained sound. At this latter date another ulcer had developed at a little distance from the scar. On both occasions Mr. Tay examined the excised parts with the microscope, and he informed me that the characters of epithelial cancer in its ordinary form were definite, there being among other conditions abundance of nested cells.

Mr. Nayler's case.

Mr. Nayler records a case of cancer following lupus in a man aged 38, who had for years been under Mr. Startin's care. A fungatory growth as large as a walnut was developed, and had passed through the cheek into the mouth. It was freely excised by Mr. Pollock. Six months after the healing there was no return.†

Abstract of report by Dr. Bayha on Lupus-carcinoma (with lithograph).

In an important report on Lupus-carcinoma, published in Brün's "Beiträge," 1887, Dr. Bayha, of Tübingen, has

* I have seen several cases of cancer in lupus patients in which the two processes were probably quite independent of each other, unless, indeed, we accept them as implying a common constitutional proclivity. In one of these a lady, Mrs. E——, æt. 38, who had long been a sufferer from lupus of the face, came to me with cancer in one breast.

† Nayler on "Skin Diseases," p. 173.

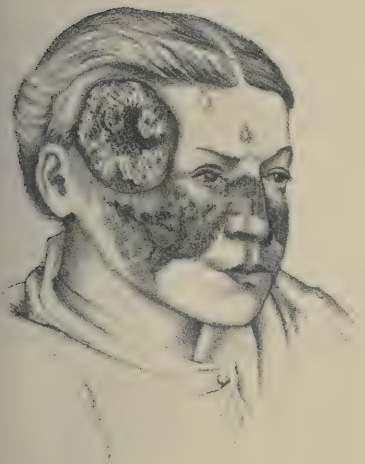


Fig. 1.

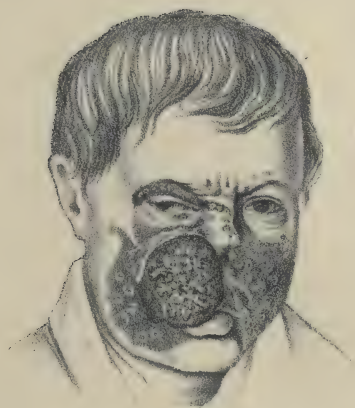


Fig. 2.

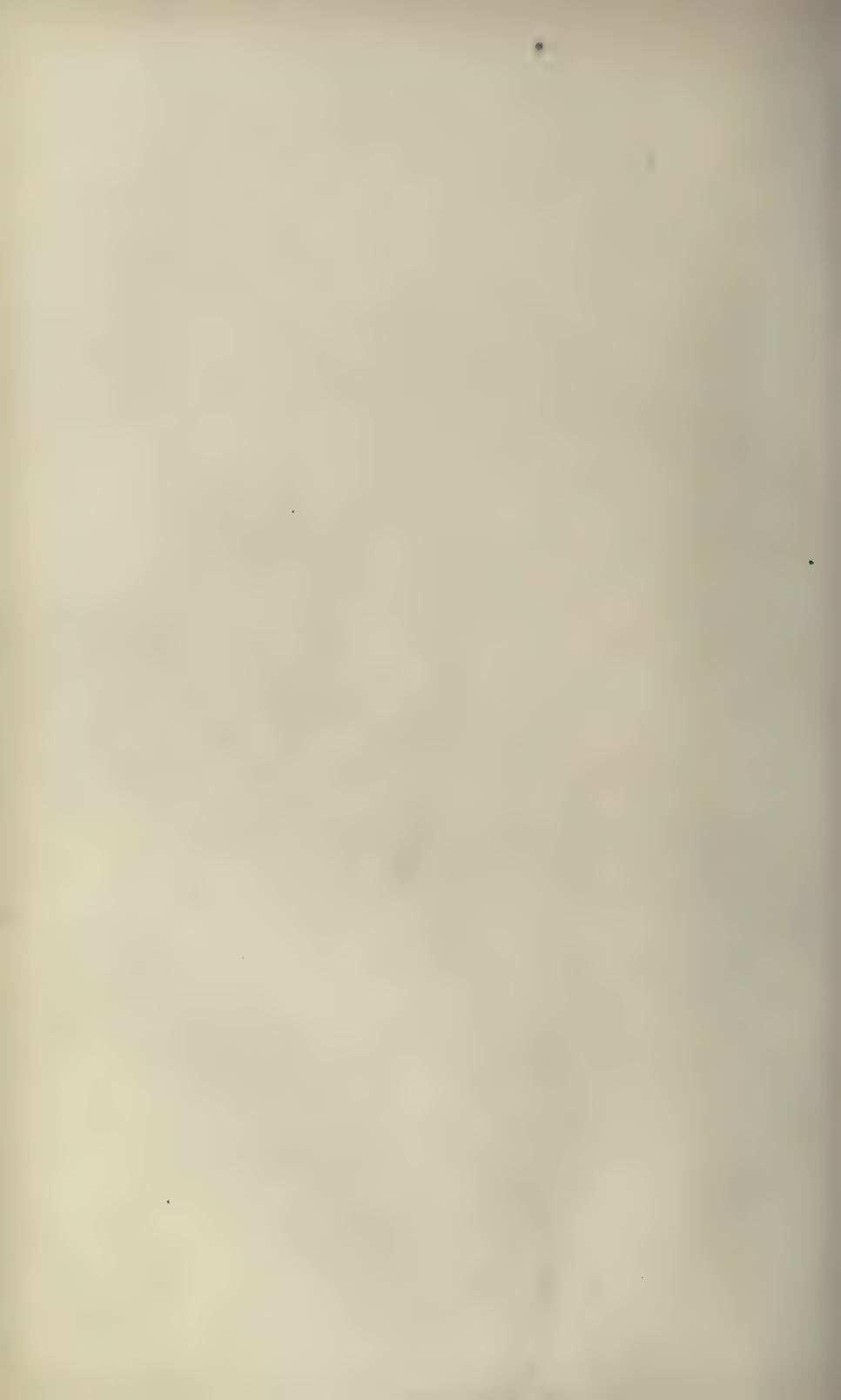


Fig. 3.



Fig. 4.

Cancer following Lupus.
(Copied from Dr. Bayha.)



recorded, not only his own experience, but has given a valuable summary of our knowledge on the subject.

Including five cases of the supervention of carcinoma in lupus or lupus-scar observed at the Tübingen Clinic, Dr. Bayha has found record of forty-two. Eleven of these were cases in which the lupus had been healed for a longer or shorter time, and the only special points to notice in them were the rapid progress of the ulceration (great malignity), and that in one case carcinoma supervened as early as the twenty-sixth year.

The following are the brief details respecting the five cases observed by Dr. Bayha himself. Four of these are illustrated in Plate LXII. :—

CASES.—1. Johann H——, aged 28. Lupus of face since age of ten years. Epithelioma of the right cheek in July, 1869.

Death June, 1871. No secondary deposits found on post-mortem.

2. Bernhard L——, aged 62, had lupus of the right cheek for forty years. In 1860 epithelioma supervened.

3. Christian H——, aged 41, lupus since 14 of the nose, cheeks, and right upper eyelid. Epithelioma developed in the right side of the upper lip.

4. Pauline D——, aged 28. Lupus of left cheek since age of five, soon spreading to rest of face and neck. Epithelioma supervened in the cheek; it was healed with the cautery and iodoform. It grew rapidly, but the patient's death appeared to be due to iodoform poisoning. At the post-mortem, hæmorrhagic infarcts were found in the spleen and other organs.

5. Christiane M——, aged 36. Lupus of right cheek and of forehead since age of sixteen. Epithelioma of the cheek in 1881, excised; recurrence in temple in spring of 1885, removed with the cautery; recurrence soon afterwards. After a further operation the wound cicatrized rapidly.

Dr. Bayha draws attention to the early age at which cancer sometimes develops in lupus. Thus four cases occurred under thirty years, and three others under forty. Its site was in eleven the cheeks, in four the upper lip, in two the

temporal region, whilst in two it was observed in two positions simultaneously (the cheek and nose, and the cheek and breast). In most cases the lupus had existed over ten years before the supervention of cancer. Its frightfully malignant tendency was, as he remarks, shown by the fact that out of ten patients in whom the growth was excised, seven died shortly afterwards of recurrence, and only one appeared to be cured.

The following is a brief summary of Dr. Bayha's remarks respecting the pathological nature of Lupus-carcinoma :—

In the more numerous and interesting cases in which epithelioma developed in a part then the seat of lupus, the irritation of the cell-deposit and the abnormal vascularity may be considered as having had some share in its causation—just as soot and paraffin acting as persistent irritants have been shown to possess, or as a long-standing “psoriasis linguæ” is admitted to have. Further, the inter-papillary prolongations of epithelium which occur in cases of common lupus (as shown, for instance, in cases described by Lang and Hopin) must be regarded as favouring its development. Busch has described this down-growth of epithelium with formation of epithelial-nests in the prolongations, and has pointed out that it is nevertheless not true cancer, and in most cases follows the chronic course of ordinary lupus. He termed it “epithelioma-like lupus.” In sections from the real cancerous growths the prolongations were seen to branch up, and their epithelial cells, becoming smaller, to intermingle with the round cells of the lupus deposit.

DISEASES OF THE EYE.

No. V.—*Double Optic Neuritis rapidly passing into complete blindness—Patient a robust man whose relatives were gouty, but who had not himself suffered—Severe headaches the only concomitant symptom—Recovery with white discs but fair vision—Record of state four years afterwards.*

ON May 25, 1886, I saw, with Dr. Foreman, of the Stoke Newington Road, a very interesting case of double optic neuritis for which we could assign no other cause than that it was probably in association with gout. Our patient was a retired builder, aged 50, who had been accustomed all his life to eat largely, and to take beer pretty freely. He had never been intemperate, and had enjoyed excellent health. He had never himself had any single gouty symptom, but he was a florid stout man, and his father and one of his uncles had suffered very severely from ordinary paroxysmal gout. When I saw Mr. P—— he appeared to be in good health, and excepting that he was quite blind he had no symptom of any derangement of function. His blindness had been about three weeks coming on, and the only exception to its completeness was that he could just recognize a candle-flame held to the temporal side of his left eye. His pupils were widely dilated with atropine. There was not the slightest dulness of the media, nor any congestion of the eyeballs. With the ophthalmoscope both discs were seen to be somewhat swollen, and their margins hazy. The changes were most definite, but they were not extreme, and did not approach the condition of “choked disc.” The history of his illness was as follows: On the 22nd of April,

that is nearly five weeks before my visit, he had complained of being chilly, and of having "caught cold." He continued to go about as usual during the next fortnight, but had some cough and aching in the limbs. At the end of this time his cold left him, and he began to suffer from shooting pains in his eyes, temples and forehead. For these he consulted Dr. Foreman, and the diagnosis was "Neuralgia." The pains were sharp and shooting, and would come and go. They often woke him in the night, but never really made him sleepless. As they were attended by considerable intolerance of light he was kept to a dark room, and atropine was used. Under these conditions it naturally happened that there was no exact appreciation of the time when his sight began to fail. When his headache ceased and light was admitted to his room it was found that he was practically blind. This was only three days before I saw him. Probably the failure of sight had been in progress for about three weeks, for his wife remembered that once while in chapel he had put down the book because it made his head ache. The right eye had failed before the left, and the pain had been chiefly in it. The pain in the temples had suddenly ceased after a blister, and with its cessation the failure of sight had become nearly complete.

The subjective symptoms, with the exception of headache, had been exceedingly slight. He had had no flashes of light, and had scarcely noticed that his sight was failing until he was blind. Probably this was in part to be explained by the fact that one eye failed before the other, but chiefly because his headache and intolerance of light prevented him testing his sight. He had scarcely even noticed that he was in fog.

We prescribed mercury in small and frequently repeated doses with the intention of inducing ptialism rapidly.

On June 11th, three weeks after the first visit, I again saw Dr. Foreman's patient at his own house. The gums had been decidedly sore for the last four days. He has been kept in the house under a diet chiefly of slops. Although he complains of feeling very weak there are no symptoms of ill-health, and were it not for his blindness he would be quite

well. His left eye, with which at the last visit he could see a little at the extreme temporal side, is now quite blind. I could scarcely get him to tell when the hand passed in front of a candle-flame, held close in front. His right eye, which at the date of last visit was utterly blind, is now beginning to improve, and he can count fingers with it. He has not the least headache. We decide to continue the mercury, but in less frequent doses.

In October he called on me at my house, and I made the following note :

He looks and feels perfectly well. He can just puzzle out 20 at 10". The two eyes are much alike.

He has been to Ramsgate, and has taken his ale again, and has got quite strong again. No medicine has been given for twelve weeks past.

After this note I did not see Mr. P—— again for three years. In January of 1889 Mr. Foreman wrote to me, and reported him in good health and seeing fairly well.

In April of the present year (1890), Mr. P—— called upon me in the hope that I could order spectacles for him. I made the following notes :

He is now aged 54. He sees $\frac{2}{5}$ with R, $\frac{2}{6}$ with L, reads without glasses only 16. He has been in perfect health since I saw him. He now comes hoping for spectacles. His fields are somewhat limited in their outer parts. He can see to write his name, and can make it out when written. The optic discs are almost as white as white paper. They are quite clean, and the retinal vessels upon them are of full size. I cannot appreciate any material shelving of the disc, nor see the cribriform fascia very distinctly. The left disc is uniformly pale in all parts; the right shows a difference, the inner two-thirds being less pale than the third next the yellow spot. There are no retinal or choroidal changes whatever, and the margins of the discs are distinct. The pupils are in all respects normal.

COMMENTS.—The above case is one of an important class which as yet our Ophthalmic text-books have scarcely recognized. We have in it an example of acute optic neuritis without obvious cause, and without any concomitants as

regards other disorder of the nervous system or of the general health. As a period of four years has passed and the health is still good, we may feel confident that no serious organic disease is present within the cranium. It may seem to be an easy resource to diagnose gout, yet I confess that I see little else to suggest. That gout does cause peripheral neuritis, as for instance in the case of sciatica and brachyalgia and many forms of neuralgia, there can, I think, be but little doubt. Was the case one in which the optic nerves were affected in a manner similar to what the sciatic suffers in sciatica? The patient had gouty relatives, and had lived in a manner likely to produce it. I may note, however, that if we diagnose it as gout, the diet test wholly fails us. The patient had been accustomed to take beer pretty freely, and never had found that it disagreed with him. He had never noticed that his urine became thick.

No. VI.—*Loss of Sight in one eye only—Diagnosis of gouty neuritis, but without any history of gout.*

A farmer from S—— came to me on the 24th of March on account of blindness of his right eye. The pupil was widely dilated, No. 14 at least, and it only moved in a very slight degree on suddenly exposing its fellow. The left eye was perfect, but with the right he could not see the windows, and had no perception of shadow when the hand was passed in front of it. He was a stout, florid, very healthy-looking man. No sort of illness had preceded the failure of sight. He gave a graphic account of the progress of the attack. Just one week before I saw him, on a Thursday, he felt a slight pain across the right eyebrow. This was attended by some running of tears, and then he found that the eye was dim. After these symptoms had lasted a few hours he went to look in the glass, and found his pupil much enlarged. On the following day, Friday, he could still see large objects. On Saturday he could not see anything straight before him with the affected eye, but could dimly see things on all sides. On Sunday he was quite unable to see anything, and had

remained so since. On ophthalmoscopic examination I found the edges of the optic disc concealed at all parts excepting immediately opposite the yellow spot. At this part they were perfectly clear. There was no great swelling of the disc, and the changes did not extend far into the retina. The artery was of good size, and the veins turgid. In the other eye there were no morbid changes, excepting a small patch of opaque nerve-fibres below the disc. Mr. R—— complained that in this eye he had very similar feelings to those which preceded the loss of the other—with pain in the brow, &c. On careful inquiry it did not appear that he had had any headache or other indications of cerebral disease. He said that sore throats had been prevalent in his neighbourhood and that he had had a slight one.

Mr. R—— came to me again on May the 25th. During the interval he had taken mercury, and had his gums very sore. He also had abstained entirely from stimulants. His eye remained quite blind, and there had been no further symptoms threatening the other. I now found his disc decidedly pale, especially on the side next the yellow spot. It was slightly swollen, and its edge was indistinct on the temporal two-thirds (inverted image). Thus there had certainly been a descending neuritis. He was in all respects in excellent health, though he was much pulled down by low diet, &c. He had no headache whatever. His pupils were now of equal size, and not larger than No. 3 when exposed to the light. The pupil of the blind eye dilated when the other was covered, but not to larger than No. 7. It remained at this size, and uninfluenced by sudden exposure or shading. It appeared to be possible that the observation as to the early dilatation of the pupil in the former note was an error, and that it might have been due to atropine. He insisted, however, that his statement was correct, and that he had noticed the dilatation before he saw his surgeon or used any application. His wife thought otherwise. His aspect is quite that of a gouty subject, but he still insists that there is no gout in the family.

COMMENTS.—In this case, as the preceding one, an interval of several years has elapsed since the attack of neuritis, and

the patient remains in good health. The cases differ in that in one both eyes were affected, and a good degree of recovery took place; whilst in the other only one eye suffered, and it remained permanently blind. In both the patient was an adult man of gouty aspect, but without any history of gout.

No. VII.—*Blindness of one eye only with white disc
—History of so-called “sun-stroke” ten years
ago with paresis of several nerves in same orbit
—No aggressive nerve disease.*

The following case is only a fragment. I had seen its subject, in the first instance, ten years before the notes now published were taken, but have been unable to find any record of my first observations. Its value consists in its being an example of one-sided optic neuritis with blindness of the affected eye, and without any tendency to aggressive changes in the nervous system. As such it may be placed in company with the preceding one, and both may help to the formation of rules of prognosis.

Abraham Brownhill, aged 45, a machinist on railway. He states that I saw him ten years ago for loss of the sight in his left eye. It was “from sunstroke.” He was then living at Wellingborough.

At the present date the right eye remains perfect, whilst the left is still quite blind. The pupils are of equal size, but the left dilates when the right is covered. He complains that there is often a heavy pain in the back of his head. If he remains too long in bed, as on Sunday mornings, it always brings on headache. He has had no illness during the last ten years, except once, “a touch of pleurisy.” He suffers from eczema in his legs, which is the cause of his now again coming under care. He has no other nerve symptoms.

He says that, on the former occasion, I said to the pupils present that the first, third, and sixth nerves were all involved, and he remembers that he had lost smell and taste. The disc is now uniformly white, but the central vessels are of normal size. The whiteness has a slightly dirty grey tint.

There are one or two tags of iritic adhesion, but they do not interfere with the action of the pupil.

The eyelid does not now droop, and he can move the eye in any direction. The eyeball is decidedly a little prominent.

He is not liable to worse headaches than formerly. They never lay him up. He is "often dizzy," and "walks sideways at times." This occurs at intervals of months or years.

His smell and taste, which were lost, have quite recovered. His hearing is perfect, and never was impaired.

REMARKS.—I have given the patient's name in the above narrative on the chance that some of my readers may perhaps be able to assist me as regards the sequel. It is several years since my notes were written. I believe that there was no history of syphilis, but upon this point I regret that my notes give no information.

No. VIII.—*Symmetrical Amaurosis occurring quite suddenly in a smoker exposed to much heat, and persistent for seven years without alteration.*

It fell to my lot on September 28, 1877, to have to examine, in reference to a Government pension, a robust-looking man aged 40, who had formerly been in the navy. Almost accidentally I discovered that his sight was very defective, and on further inquiry learned that he had been disabled by it for six or seven years past. Yet during that time no other nerve-symptoms had shown themselves, and as stated, he appeared in perfect health. It became, therefore, of much interest to ascertain what was the nature of his amaurosis.

His failure was equal in the two eyes, and he could see only $\frac{2}{10}$. His pupils were sluggish. The optic discs were pale, but not much atrophied, and the central vessels kept their normal size. The pallor was not greater on the side next the yellow spot as is usual in tobacco cases, but the symmetry of the condition suggested that cause. The man had experienced no failure of sexual power, and his wife had borne him ten children in eight years.

His history of the failure of sight was that it occurred suddenly. He was at the time serving on ship-board in the

tropics, and exposed to extreme heat. He went to sleep one night quite well, and in the morning awoke with headache across the forehead and great dimness of sight. He believes that his sight was as bad then as it is now. He was under medical care for some days on account of the headache, and after a time he regained perfect health, his eyes remaining, however, as at first. He was smoking at the time this happened, and had continued to do so ever since, but not in any excess. He denied having ever had syphilis. At the time of my examination of him he was not by any means clear in his statements, but I could not get him to deviate much from the above account that he lost his sight in a single night, and that he had never since been either better or worse. The only difference that he had noticed was that at first he saw much mist, and now he simply could not see clearly. I have in several other cases had a similar history given me of sudden failure, and in most cases the patient was at the time much exposed to heat and sun-glare. I have not, however, been able to obtain in any of them a history extending over so long a period. In several closely parallel cases improvement took place at once on disuse of tobacco. It is quite possible that we have in this case an example of tobacco-amaurosis remaining stationary, but it is an exceptional case, for I believe they almost always get either better or worse—better if the tobacco be left off, and worse if, as in this instance, it be continued.

No. IX.—*Acute Neuro-retinitis after a severe illness—Retinal conditions much like those of Albuminuria—No albumen found—Recovery with blindness—Absence of Menstruation.*

Amongst the cases which bear with great interest upon the question of prognosis in optic neuritis is that of a girl aged 10, who was brought to me by Dr. Brett, of Watford, in 1879. Her eyes presented very extensive and conspicuous evidences of neuro-retinitis. The discs were swollen, elevated and hazy. The trunks of the large vessels were in parts buried, and the edges of the choroid were very extensively

concealed. The large veins were exceedingly tortuous and very full. Near to the yellow spot in both was a group of very white streaks and dots, the arrangement of which was peculiar and not exactly like that seen in albumenuria. The streaks did not radiate from centres, but began from a baseline much like a touch of a greasy finger sideways on glass. The mixture of dots and streaks was also a peculiarity, and further the streaks were not lines of equal width in all parts, but rather microscopic lagoons. The appearance might be compared to quicksilver spilt on paper and arranging itself in globules of various sizes, with some streaks interspersed. I do not know of any published portrait which represents accurately this arrangement. Jäger's 27th Tael reminds me of it a little, but is on far too gross a scale. I may just mention that I sent Miss G—— to my friend Mr. Nettleship for his inspection, and he declared that the white streaks were indistinguishable from those of albumenuria.* In some minor points, as I have just said, they were, I think, distinguishable; still, I admit their similarity was close. There were no hæmorrhages but extensive tracts of the retina were hazy. Thus then it will be seen that we had neuro-retinitis with deposits resembling those of renal disease. Let us now turn to the history of the case, and see if it fitted with such a diagnosis. Dr. Brett told me that he had repeatedly examined the urine and had never found albumen, and, further, the history pointed clearly to brain disease as the starting point. Our patient was of healthy family, and until her present illness had herself been robust and very active. Her illness began in March (that is seven months before I saw her), and the first symptoms were feverishness and headache. These were at first thought to be due to biliousness, but after a few days it became evident that there was something much more serious. Sickness set in and there was most obstinate constipation. Headache never became

* Mr. Nettleship wrote:—"I have just seen the girl with Dr. Brett, and am much obliged for the opportunity. Intense neuro-retinitis with great swelling of discs, and numerous white patches near Y. S. indistinguishable from results of albuminuric retinitis. The state of the discs and extreme tortuosity of vessels would of course lead one to suspect that it had been essentially a cerebral case and not a renal case with cerebral symptoms. Everything is worst in right eye."

very severe, but after ten days or so coma came on, and she lay for nearly a fortnight quite insensible and daily expected to die. During this time her urine and fæces passed involuntarily, and she also had squint. Under vigorous treatment by mercury and iodide she at length recovered; but the squint continued, and her sight was found to be defective. From this time forward she never used her sight for reading. It was uncertain as to the precise extent of defect, as no tests were used; but until a month before she came to me it was supposed that she saw fairly well with the left eye.

From the above facts it will be seen that the loss of the function of sight continued after recovery as regards the brain had well set in, and it was still (six months afterwards) advancing. The girl had been sent to the seaside; she had recovered almost her usual state of health, was free from headache and had all her other special senses perfect, and yet her sight continued to fail. I might have said that her pupils were large, and that of the right eye larger than the other; both were sluggish, and the right almost motionless. I inquired particularly as to the state of the brain, and was told that at first it was feared she might pass into idiocy, but that now she had no indications of mental weakness. Her temper, memory, &c., were as good as before.

Under what name are we to place the illness through which this child had passed? The diagnosis of tubercular meningitis was offered at the time, and I think it will be agreed that it was the most probable. But when recovery took place doubts were felt. The old name "cerebral fever" might be used, but it implies nothing that is definite. Was it an attack of inflammation of the subarachnoid spaces at the base of the brain, not of a tubercular character and therefore amenable to mercurial treatment? In connexion with optic atrophy after neuritis and severe cerebral illness I have often received a precisely similar history. I have been obliged to believe that there is a form of illness not to be distinguished at the time from tubercular meningitis, which is yet not exactly of that nature. If it be such, then tubercular meningitis may be recovered from and its subject may remain

perfectly well for indefinite periods afterwards, often, however, wholly or partially blind. The blindness in most cases is present from the first. I have often in such cases seen, in addition to the optic atrophy, white spots grouped near the macula, and have sometimes compared their appearance to that of spider's eggs. Whether the subjects of such cases remain well through many years afterwards is more than I can say; but I have certainly seen several in which every trace of disease had disappeared and the good health was continued at periods varying from one to four or five years afterwards. In one case in which I was interested, a girl of fourteen or fifteen who had been admitted into a blind school died four or five years after the cerebral attack of an illness which was, I believe, supposed to be tubercular.

The subsequent progress of this patient may be briefly stated. She has remained blind, but has not developed other cerebral symptoms. In 1881 Dr. Brett wrote to me that she could just distinguish shadows, but not objects. Her general health was very good, and she had learned to knit. In 1884 Dr. Brett was again good enough to report, and much to the same effect. Our patient was now twenty years of age and had never menstruated. In an elder sister (23) a like failure of the menstrual function had occurred and was associated with weakness and pallor. Their brothers (ten) were in good health.

Quite recently (1890) I have again heard from Dr. Brett, who takes a most kind interest in the case. It is now eleven years since the illness, and the young woman's condition is much as it was. She is nearly blind, but in good general health. She has never menstruated.

No. X.—*Gout and Syphilis—Spontaneous Gonorrhœa — Unsymmetrical Retinitis Pigmentosa probably of syphilitic origin.*

The following case possesses several distinct features of interest. The patient was the subject of both gout and syphilis. He afforded an example of that peculiar form of spontaneous gonorrhœa to which gouty persons are some-

times liable. He had suffered much from recurring iritis, which no doubt was again gouty. He was the subject of the peculiar serpiginous patches in the glans penis which I described in the last number of the ARCHIVES. These were of a syphilitic lupoid nature. He had also patchy sclerosis of the tongue, in part syphilitic, and in part due to smoking. Lastly—and this is the feature of most interest—he was the subject of retinitis pigmentosa and posterior polar cataract in one eye only. The want of symmetry takes the case out of the category of ordinary retinitis pigmentosa (which is always symmetrical). The form which occurs in the subjects of syphilis, whether inherited or acquired, is on the contrary almost always non-symmetrical. It is an imitation of the type form but with differences. As an example of this I incline to claim the present case.

Mr. B—— age 56, whom I had seen a year before for gouty iritis, came to me on August 11, 1873, for profuse discharge of pus from the urethra which had lasted three weeks. There was no scalding whatever. Twelve years ago his eyes had been attacked by iritis, and he had had many attacks in them. Two very bad attacks were in the right eye. The sight in the right eye has been reduced to mere perception of light; but with the left eye he can read well. Since I last saw him a year ago, he has had recurring eruptions in various places. He has now some serpiginous patches on the glans penis, and his tongue is sore with large white patches. There is unsymmetrical retinitis pigmentosa. The retina of the right eye is covered with specks and patches of black pigment; these are very numerous and confluent in places. They are more plentiful at the periphery, but come up to the disc margins. There is no absorption of the choroid. There is also slight posterior polar cataract. The disc is waxy and grey, and the vessels are reduced to the smallest possible threads. It is fifteen years since he first consulted a doctor about his eye. It had, however, been failing slowly for some years before that; at the time of the great comet (1857), he remembers that he had been kept in one room by the state of his right eye for three weeks. This probably gives the date of the first attack of retinitis.

Mr. B—— at the time that the above notes were taken was about 56 years of age. He had suffered from syphilis in early life, and had had much irregular treatment for recurrent symptoms chiefly affecting his tongue and skin. He was still in fair health. I regret that I cannot complete his case, as I have been unable to find any more recent notes.

No. XI.—*Changes characteristic of Choroido-retinitis in one Eye only, consequent on a very severe contusion of the Eyeball fourteen years previously.*

I. W——, aged 31, a florid man with red hair, came to the Blackfriars Hospital in 1874 for sycosis tarsi. Having been told that his left eye was almost blind (being unable to count fingers), I made an examination, and a somewhat unusual condition of things was discovered. There were numerous very thin filmy opacities in the vitreous, exactly like the wings of insects. In the retina were numerous coal-black pigment deposits, forming small, nearly round patches looking, in the inverted image, about as large as pins' heads. They were present in almost all parts, and nowhere did they assume the delicate lines or branching forms which occur in true retinitis pigmentosa.

He believed that it had all resulted from a blow received fourteen years before. He was kicked violently by a horse, and afterwards the eyelids and adjacent parts swelled up very much; and from the day of the accident he had never seen better than he could on admission. The other eye was perfect and free from pigment deposits. He denied ever having had syphilis, and it seems most probable that his own impression as to the cause was correct.

In connection with this subject I may refer to a paper by my eldest son at page 120 of Vol. IX. of the Transactions of the Ophthalmological Society. He reports a case, with ophthalmoscopic portrait, and gives a *résumé* of our knowledge as to the effect of blows in the eye in causing choroido-retinal pigmentation.

No. XII.—*On changes in the Eye in connection with Senility.*

In Mr. H——'s case it was of interest to note that changes had occurred in different textures of the eye simultaneously. Thus there were striæ of opacity in the lens, changes at the yellow spots, and great pallor of the discs. The conditions were quite symmetrical. There could be little or no doubt that they were due to senility and senility only, for Mr. H—— was a very healthy man, of temperate habits, and in good general preservation for his years. His age was 79. He walked erect, had an excellent memory, and was still accustomed to come from his country residence to his city office once a week. It was his special senses only which were failing him. He was becoming both deaf and blind. It is not without interest to note that his wife, who was within a year of his own age and in equally good health, was losing her hearing gradually in exactly the same way as her husband. As yet, however, her eyes served her well. There was yet another fact to be observed illustrating, I think, a not uncommon difference in senility in the two sexes. Whilst Mr. H—— had become thin and dry-fibred, retaining good colour, Mrs. H—— was fat, flabby, and pale, looking almost like the subject of myxedema.

To describe the changes in Mr. H——'s eyes, I may say that they consisted in peripheral lines of opacity in the lenses; in great general pallor of the optic discs, and in absorption changes at the yellow spots. The latter consisted in the production of groups of whitish patches of considerable size, and of roundish or irregular forms. These were placed exactly at the yellow spot in each eye, and were limited to these regions. They were much larger in size and more restricted in position than are the little white dots so frequently seen in the form of senile choroiditis known as Tay's Amaurosis.

The whole subject of senile changes in the eye seems worthy of more systematic study than has yet been given to it. We have long recognized various forms of opacity of the lens (senile cataract), but respecting the white atrophy of the

optic nerve and different types of choroido-retinitis which occur to the aged we know but little with any precision.

No. XIII.—*Case illustrating prognosis in reference to hereditary syphilitic affections of the eye—Very extensive Choroido-retinitis with waxy discs.*

Miss M——'s eyes illustrate some very important points in reference to the choroido-retinitis due to inherited syphilis. They show its unequal severity in the two eyes, its absolute arrest, and the possibility of fair vision being retained in a much damaged organ. Miss M—— pursues with much industry and some success, the pursuit of an artist, yet one eye is quite blind, and the other has suffered severely from choroido-retinitis and is constantly affected by nystagmus.

Miss M—— has a sunken nose and deformed physiognomy. All her teeth are dwarfed, and the upper incisors characteristically screwdriver-shaped. She believes that her left eye has been blind from infancy. She had "a grey cataract in it." This was removed by needling some six or eight years ago, and we can now, through holes in the capsule which remains, see the choroid. There is literally not a single portion of it which has escaped disorganization; everywhere it presents masses of pigment accumulation and streaks of exposed sclerotic. The disc is pale and waxy and the arteries extremely small. In the other eye the disc is, though in much less degree, pale and waxy, and the retinal vessels are decidedly diminished. Near to the disc there are ill-defined patches where the hexagonal layer is absorbed and pigment accumulations are seen. In the periphery and also at other parts are many minute lines and streaks of pigment, like those of retinitis pigmentosa. The eyeball oscillates so much that minute inspection is difficult.

Miss M—— tells me that about eight years ago she was for four months so far blind that she could only just tell light and strong colours. At this time she had much pain in her eyes, and probably she went through an attack of keratitis. Her evidence is clear that for some years, in spite of close

work, the right eye has got no worse. She is under my care now for a form of epilepsy.

No. XIV. — *Chronic Conjunctivitis and Ulcers on Corneæ in association with psoriasis—Psoriasis sixteen years—Inflammation of Eyes three years—Probable influence of exposure to fire heat.*

A disease to which the name "Pemphigus of the Conjunctiva" has been given is well known, and during recent sessions has excited considerable interest at the Ophthalmological Society, several interesting examples of it having been brought before the society by Mr. Lang and others. In that disease the conjunctival sac becomes gradually obliterated after repeated attacks of inflammation. The mucous membrane itself does not usually show bullæ, and the name Pemphigus becomes appropriate only because the patient usually presents some form of skin disease attended by vesication. It is, I think, but seldom, however, that the eruption is a well-pronounced pemphigus. A case which I have now to relate is of great interest in connexion with the malady to which I have referred. It gives strong support to the belief that there are conditions of dermatitis which may be attended by disease of the conjunctival sac. The skin affection, however, was not bullous, but a well characterized psoriasis. My patient was a man named G——, aged 48, who was sent to me by Mr. Harrison, a very able surgeon at Braintree. He was in good health, but had suffered for many years from psoriasis. His face was much disfigured by what appeared at first to be very severe lippitudo. The lower eyelids were everted, and a rim of red swollen conjunctiva exposed. On close inspection it was seen that the eyelashes were not themselves involved in either the upper or lower lid. They had not been destroyed, but were simply displaced by the swelling and eversion of the lid. The conjunctiva was thickened and vascular, and the lower palpable sac was entirely obliterated. The thickening of the membrane on the globe was in fan-shaped bands, resembling ill-marked pterygia. These false pterygia had their apices near the centre of the cornea, and

the surface of the latter was ulcerated where vascular. The upper palpebral sulcus was not much affected. Near the centre of each cornea were several hazy ulcerations. The condition of the two eyes was much alike. The state of the man's tongue gave support to the belief that there was a tendency to inflammation of the mucous membranes in connection with the constitutional cause, and that the state of the eyes was not due either to the arsenic which had been taken for the psoriasis, or to any accidental or local cause. The tongue showed red abraded patches, which were arranged chiefly on its sides. The patch on the left extended nearly to the middle. The nails also were affected. They were inflamed at their roots and edges, and had become roughened. The skin disease was an inflamed psoriasis, severe and very copious on the backs of the hands, but occurring also all over the limbs, trunk, and head. In some places its patches were polished and smooth like lichen planus, but for the most part it conformed to the type of common psoriasis. No special diathesis could be traced in the patient. The psoriasis patches showed a tendency to contract and make the skin tight, and on the backs of the hands were many cracks. Patches of ordinary psoriasis occurred on the tips of the elbows and on the knees.

Mr. Harrison wrote to me that arsenic had been repeatedly given, and over long periods, and had not appeared to do good. The eyes had been very painful, and the skin used to smart much where the fissures were. His occupation was that of baker and confectioner, and the heat of the fire had probably made his hands and face worse. It may have been a material influence in locating the disease in the eyes.

I subsequently procured for the patient admission into the London Hospital under the care of Mr. Waren Tay, and he derived much benefit. I believe, however, that he relapsed soon after his return home. A portrait has been preserved in the collection of the Royal College of Surgeons.

DISEASES OF THE NERVOUS SYSTEM.

No. XIX.—*On the sensation of throat-grip in Ataxy.*

The girdle pain of locomotor ataxy is well known. It is, I think, always assigned to the chest, and I do not know whether any one has described what might be called the throat girdle, or sensation of strangulation, which is not very infrequently complained of in patients in an advanced stage of this disease. They describe it as being a very distressing sensation, beginning with a feeling as if it was necessary to swallow, but impossible to do so, and advancing to one as if the throat was gripped outside. There is also a feeling as if suffocation were impending, but never any real difficulty in drawing breath. The patients who suffer from it almost always imagine that there is some swelling of the glands. Other throat and nose symptoms are sometimes present in conjunction with it, such for instance as an irritable cough, or a tendency to sniff while talking. I have seen several patients who offered very marked examples of this throat girdle sensation. They have all been in advanced stages of the disease. A gentleman came to me the other day whom I have been attending for years for ataxy after syphilis, and who is now quite blind. He was in great alarm on account of an attack of throat sensation such as I have described. It has lasted during about twenty-four hours, and he described the sensation as having been very distressing. There was nothing whatever to be discovered in the throat.

No. XX.—*On the sensation of nose-grip in various forms of Neurasthenia.*

There is another symptom occasionally met with in the earlier stages of various nerve disorders, but especially in

ataxy, which patients compare to the feeling as if some one were gripping them across the nose. I see not a few patients with this symptom who come with the belief that there is some syphilitic disease of the bones of the nose. But there is nothing of that sort ever to be found. The sensation is always located in the bridge of the nose, and not in the tip, and it sometimes lasts for several weeks together. I have encountered it chiefly, as just suggested, in men who had at some previous time suffered from syphilis. In some it has proved to be a premonitory symptom of ataxy, but not, I think, by any means in all cases. In some it has seemed to be indicative only of defective nerve tone.

No. XXI.—*On some of the causes of vague symptoms of nerve disorder occurring in the lower extremities.*

In cases of failing power in the lower extremities or of abnormal sensations, we have constantly to ask two principal questions. They are these: First, are these symptoms due to syphilis? and, secondly, are they caused by any one of the modes of sexual excess? It is often exceedingly difficult to decide this point, and in not a few cases we have to come to the conclusion that both causes have been at work, and that in devising measures of treatment it will be wise to try to allot the respective shares rather than to refer the phenomena exclusively to one. The subjects in whom these difficulties occur are usually men, and in some cases they have had long treatment, and we often have to take into consideration the question whether the abuse of the iodide of potassium may have had a share in reducing the tone of the nervous system.

The case which I have now to relate, although very like many others, will, I think, place a certain part of this question in an unusually clear light.

Mr. H—— was sent home from South Australia on account of symptoms which threatened paraplegia. He brought to me a very excellent account of his case from his surgeon, whose name, for obvious reasons, I must not record. It appeared that Mr. H——, who was a bachelor of about 39 years of age, had been “feeling funny in his feet.” He had experienced a

sense of formication in the feet, and a sensation as if cold wind were blowing over the feet and legs. He had also felt his legs weak, especially if he stood long; and once at a public meeting he had nearly fallen down. The same thing had subsequently happened whilst playing at billiards. Yet with this he was apparently a very powerful man. His reflexes were normal, and he had no ataxic pains. As there was a remote history of syphilis, his surgeon had prescribed the iodide in full doses, and sent him home to England. When he went on board the steamer he could only just manage to walk. During the voyage he took no medicine, and when he reached England and came to me he was all but well. The leg symptoms had vanished, and his only complaint was that he felt somewhat weak.

A fortnight after his arrival in London he came to me again, in a state of great despondency. His legs ached and felt so weak that he could scarcely stand, and the soles of his feet were constantly pricking. He compared the sensation rather to the constant fizzing of soda-water than to pins and needles. The feet felt asleep, and he could not bear to stand still a minute. With these sensations in the feet he had also, he said, a cold, sticky feeling in his hands, as if they were sweating, and he must wash them. Add to these local conditions, he said that he felt languid, unfit for exertion, and very unwilling to attend to business.

I should not have thought it worth while to describe these symptoms in so much detail, but that I think we may with great confidence assign them to their true cause. On returning to London, Mr. H—— had resumed relationships with an old mistress, and after a period of enforced celibacy on ship-board had been indulging very freely. He himself suggested to me this explanation quite spontaneously, but it was exactly what I had suspected before he spoke.

No. XXII.—*Paralysis of third nerve—Rapid and almost sudden recovery.*

A man (J—— J——) who was under my observation in August, 1878, presented a somewhat unusual combination of

conditions. His recovery was also exceptional in its rapidity. His right third nerve was almost completely paralyzed, but yet his pupil was not dilated. He had ptosis, and was unable to use any of the third nerve recti; nor could he effect accommodation. His two pupils were about No. 2 in size, both dilated a little when covered, perhaps to 3, and both contracted again when exposed. The left acted perhaps a little more rapidly than the other, but both were very slow and moved but very little. I inferred from this at the time that probably his vaso-motor nerve was defective in both eyes, and that this explained the non-dilatation of the right pupil.

The cause of the paralysis is not easily assigned. The man denied syphilis. He had married at twenty-two, had lost his first four children in infancy, but had five living. He appeared to speak candidly, and assured me that he was never in his life exposed to the risk of syphilis. Yet he said definitely that he felt much better after a week's treatment with iodide. His ptosis, &c., had been preceded by a week's headache, or rather pain over the affected eye. This pain was new to him, for he had previously always had good health. It was three weeks since the lid first drooped. He had double vision and giddiness if both eyes were open. He had had bad nights, and had slept in the daytime. There were no other symptoms of locomotor ataxy. He had no shooting pains, no stomach attacks, and he walked well with the eyes closed.

Six weeks after the above notes were taken I saw the patient again, and made the following note.

September 16, 1878. Ten days ago he suddenly found that he could lift the right upper-lid, and now there is scarcely a trace of ptosis, and the recti act well. It is remarkable how suddenly the improvement occurred. He says that one evening whilst at work he suddenly found that he could lift the lid and use both eyes together. He was taking potassium iodide, in five-grain doses. He feels quite well, and has no giddiness. He has regained perfect accommodation, and reads No. 2 at 10" as well with right as with left.

No. XXIII.—*Paralysis of one third nerve, without history of cause—Rapid and permanent recovery.*

I well remember seeing, a great many years ago, a case which was similar to the above, in the fact that whilst all specific history was absent yet the iodide cured. It occurred in the person of a medical friend. He was a married man, of middle age, and assured me that he had never had syphilis. He had paralysis of one third nerve. There were no concomitant symptoms, and he was in good health. The eyelid drooped over the eye. I said, "Syphilis or no syphilis, I know of nothing but the iodide for you." We gave him it, and in a fortnight or less he was quite well. I then said jokingly, "Well of course it was not syphilitic, but I advise you whenever you ail anything in future to take iodide of potassium." He laughed, but still with seeming sincerity asserted that he had never had syphilis. I saw him repeatedly during several years afterwards, and am not aware that any recurrence ever took place.

No. XXIV.—*Partial Cycloplegia in both eyes—History of an attack of paralysis of the third nerve in one eye ten years ago—Syphilis possible.*

Mr. S——, aged 50, a pale gentleman, consulted me Jan. 20, 1874, for defect of sight. He could read No. 1 with R. with + 20, and also with the left with + 9; with both he could see $\frac{2}{3}$ with a little difficulty. The pupil of the left was nearly twice the size of the other and almost motionless, but it did alter a little on strong sudden exposure. The pupil of the right was smaller than natural, but moderately active. He had been, he told me, under Mr. Dixon ten years ago for from three to four months for a similar attack in the other eye, but with ptosis and diplopia (paralysis of third nerve). On that occasion he got quite well. The left eye had never failed until last Christmas. He had scarlet fever thirty years ago, which he thinks left his throat weak, and he had been a little deaf for many years. He admitted a sore on the penis eighteen years ago, which was treated for

three months, but he did not recollect any constitutional symptoms. He had been married fifteen years and had four healthy children (aged 14, 12, 10, and 7 respectively). Although there was no proof of constitutional syphilis or of sequelæ, yet the occurrence on two occasions of local nerve disease was very suspicious. I prescribed iodide of potassium, but have no information as to the result. It is very possible that this case may have since developed into one of locomotor ataxia. The case is of interest in respect to the long interval between the two attacks.

No. XXV.—*Permanent contraction of the fingers into the palms after a very severe and prolonged cerebral illness — Complete recovery in other respects.*

A very curious form of contraction of some of the fingers was presented in the case of a woman named C——, in whom it had been developed in connexion with severe disturbance of the nervous system. She was a married woman, of about 45 years of age, a patient of Dr. G——'s, of Southgate Road. Great family troubles had come upon her about four years ago, and apparently in consequence of them her nervous system gave way, and she became insane. She felt as if she could do nothing, could not move, and accordingly took to her bed. After that she became violent, but she remembers nothing further until ten months later. In the interval she had been under Dr. Marshall's care in Colney Hatch. Of this period her memory is a blank. When she was recovering, for a long time she feared that she should never regain her mental power, for she could not remember names nor the commonest facts.

When she was convalescent she found her hands bandaged, with corks in the palms to keep the fingers straight. It availed nothing, however, and her present condition is that the little, ring and middle fingers are firmly bent till the tips almost touch the palm. They are quite fixed, although not ankylosed. The tendons do not start materially. The index finger

bends forward a little, but not much, and the thumb is not affected.

She can do but little with her hands, but can just manage to feed herself and to write.

Mrs. C—— has now quite regained her health, and is lively and active. She says, however, that she is easily put out, and that when made nervous her eyesight often partially fails. She is liable to profuse perspirations at night. Her bowels, formerly costive, now act well.

The above notes were taken in November, 1874. They are, I think, of interest in reference to prognosis. It may easily be the fact that some of my medical friends, especially those engaged in the treatment of insanity, may be more familiar with contractions of the fingers from such causes than I am.

No. XXVI.—*A peculiar form of local eruption of Herpetic character directly following the use of Arsenic.*

That arsenic can cause herpes zoster in its most characteristic forms, I have not the least doubt. Sometimes, however, it produces eruptions which resemble herpes in being of transitory duration and disappearing spontaneously, but which never assume definitely vesicular features, or look in the least like ordinary zoster. Of this I think we have an instance in the following case.

I ordered Pearson's solution of arseniate of soda in three-minum doses three times a day for Mrs. S——, a lady of 40, who had psoriasis. She had as a consequence, a week after beginning the arsenic, aching pains in the skin of both thighs. She could not tell what it meant, but there came out an eruption of little red spots, which lasted about a week and then faded away, although she continued the medicine.

It is, I believe, mainly to this form of eruption that the name "arsenical eczema" used formerly to be given. It will be seen that in the above case this eruption was in both sides. This is exceptional, for the arsenical forms of herpes are seldom symmetrical. A late Master of the Rolls, who had suffered all his life from psoriasis, and had taken much arsenic, became

liable to an eruption just like that above described. It always came out if he took arsenic. In order to convince me, he took small doses for three days, and then came and showed me one arm covered by a large irregular patch of little red spots. They were intensely irritable, but did not assume herpetic characters. In him the eruption was on one limb only. It faded away very quickly when the drug was disused. I have often before mentioned his case, but it so closely corresponds with the above case that I am obliged to adduce it again. Both cases are, I think, very conclusive.

No. XXVII.—*Effect of Arsenic on the Nervous System.*

Miss H——, who on account of lupus erythematosus has taken much arsenic, is not now having it. She has had none for three months. “Do you know any difference in your state?” I asked. “Oh, yes! I have not the painful tingling in my hands and feet I used to have.”

SYPHILIS.

No. XXIII.—*A case of Midwifery Syphilis with exceptional features—Insignificant chancre—High temperatures—Large Bubo threatening suppuration.*

MR. E. J. H——'s case is of much interest as an illustration of exceptional conditions both in the primary sore and in the gland swelling. He was a medical student and engaged in assisting his father, when he had the misfortune to contract a sore on the side of one of his fingers. This sore never showed anything definite or materially suspicious. It was a slightly thickened patch, excoriated in the middle, and about as large as a fourpenny-piece. He thought nothing of it until the glands in his armpit began to swell. When he came to me he had a gland mass in the armpit as large as a small fist, which was glued to the inner border of the pectoral muscle, and obviously threatened suppuration. His temperatures every evening were from 102 to 103. As there were no secondary symptoms, I felt compelled to wait a little while before venturing to feel sure that we had to deal with an infecting sore, for the bubo was exactly like that which attends the soft sore. I carefully examined his skin and throat on three occasions with intervals of a week, and then thinking that there were a few lichenoid spots of a suspicious nature, though very insignificant, I advised him to begin mercury. During the next week a very characteristic rash came out, and he had ulcers in the tonsils.

The effect of the mercury in procuring the disappearance of the gland mass was very definite, but it is right to admit that it was beginning to subside before the specific was commenced. Mr. H—— came to me first on Sept. 30th, and he

then believed the sore on his finger to be six weeks old. The sore had never been painful. He commenced the use of mercury on Oct. 12th, but his temperatures had fallen to normal, and the threatening of suppuration was at an end before its use. The glands remained afterwards exceedingly hard.

Finally, under continued treatment by mercury, he made an excellent recovery.

I give this case for the consideration of those who think that it is always easily possible to recognize infecting sores, and that the buboes which attend them are always small, hard and bullet-like.

No. XXIV.—*Doubtful diagnosis of Syphilis as to whether a sore was primary or tertiary.*

The case of Captain U—— was of interest in reference to diagnosis. He came to me with a dusky erythematous eruption which covered large areas over the backs of his shoulders and upper arms. There were some spots also on his back and chest, none on the fronts of his arms. It was symmetrical, quite superficial, and according to his statement of nearly two months' duration. I certainly at first sight took it for a secondary rash, but it will be seen that it had not a quite characteristic arrangement. It was in large patches fairly well margined, and did not in the least approach a roseola. On proceeding to search for the chancre I found his genitals perfectly sound, and although he admitted exposure to risk about three months ago, he said that he had not had the slightest local irritation. At the lower part of the orifice of his left nostril, however, there was a deep ulcer with a clean surface and very hard edges. Its edges might have been taken for those of rodent, and its general characters were like those depicted in my atlas of illustrations (Plate). It occurred to me that this might be the primary sore, and I inquired carefully as to dates. At one time he said that the sore on the nose had come first, and at another that the rash and the sore appeared simultaneously. Captain U—— had just arrived from Mexico, and during the last two weeks he

had been taking mercury on shipboard. He was a married man and was returning to his wife. He had been exposed to risk with extreme rarity and had never contracted any disease, excepting once five years ago, when he had a soft chancre from which nothing followed. During the five years' interval he had had no reminders and no sort of treatment, having been in perfect health. There could be no doubt whatever that the ulcer in the nostril and the eruption were both specific, but the question was whether they were new disease, or whether they were a relapse of what he had five years ago. Against the idea of the sore in the nose being a primary chancre, was the fact that he had had no gland enlargement in the neck. It is, I think, very rare for any primary sore to occur on any part of the face without gland implication, although such a result is common enough in the case of chancres on the penis. Had the ulcer on the nose appeared alone, there would have been no difficulty in considering it tertiary; but it was not easy to adopt this explanation when it was coincident with a secondary eruption. The result of treatment quickly confirmed the main diagnosis, for under mercury the ulcer quickly healed and the rash disappeared.

No. XXV.—*Sclerotic hypertrophy of lymphatic trunks above the corona glandis—Remote history of Syphilis.*

I have never seen the condition I am about to describe excepting in this and one other instance.

A gentleman of 45 is in anxiety about a little roll of induration just above the corona glandis. It is quite visible, and at first sight I took it for the remains of an indurated sore. On examination, however, I found that it quite encircled the penis and is exactly symmetrical, and that the mucous membrane of the reflected prepuce is not in the least adherent. It is a little sinuous, and exactly as if a piece of moderately thick whipcord had been put under the mucous membrane. It does not adhere to the deeper parts. It begins on each side close to the frænum, and winds upwards to the middle of the dorsum. Just where the cords end, each passes upwards

for half an inch, thus causing what would have been a circle to present a Λ -shaped notch. My patient is a married man, in good health and with two healthy children, but he had syphilis twenty years ago and gonorrhœa four years ago. He has known of the condition described for four years, and believes that it followed the gonorrhœa. It has never given him the slightest inconvenience, but as it has recently got larger it has made him anxious. When he had his syphilis the chancre was in the frœnum, but there has not been any tendency to relapse of irritation in that part, nor has he for many years had any reminder of his syphilis.

I have no doubt that the cords described are indurated (sclerosed) lymphatic trunks, and should think it probable that the long bygone syphilis has caused the sclerosis. Probably these lymphatics were inflamed with the chancre, and that we have an instance of the setting up of chronic changes in structures which were long ago slightly damaged. The gonorrhœa was probably the exciting cause of the recurrence. It is of interest to note the extreme slowness with which the condition has advanced, and also that it is exactly symmetrical. As yet we cannot trace the trunks higher than the dorsal edge of the septum, and there is no enlargement of the inguinal glands.

No. XXVI.—*On Sclerosed lymphatic trunks in connection with Syphilis.*

In connexion with the above note it may be of interest to describe certain little subcutaneous knots which I have no doubt are familiar to all who see much of constitutional syphilis. They occur in various parts of the body, and especially I think on the arms, are seldom bigger than a pea or horse-bean, and never quite round. They usually feel very firm and nodular, as if a small hardened tube were twisted on itself. No lines of inflamed lymphatic trunks nor any implication of the glands attends them, and they are usually painless. They do not show any tendency to implicate the surrounding cellular tissue, or to cause spreading gummata. There are usually several of them in the same patient. I have always regarded them as sclerosed lymphatic trunks.

No. XXVII.—*Long persistence of a mottled erythematous eruption in secondary Syphilis, not treated by specifics.*

I scarcely know whether the term "dappled"* might be conveniently used in reference to certain erythematous conditions of the skin. Although etymologically it is said to be derived from "dabbing," and to mean "covered with spots," yet there is a marked difference between a dappled surface and a spotted one. The more you look at a dappled horse, the less are you able to resolve the condition into one of mere spots; the tints shade into each other very gradually, and are so arranged that the groundwork rather than the spots becomes conspicuous. The state of congestion in the skin of a corpse in which the colour is produced along the lines of small veins, and certain central areas are left pale, approaches pretty exactly to what I think dappling should mean. If I am correct, there is a condition of erythema of the skin, occurring under various conditions but particularly in the early ages of syphilis, which is exactly dappling.

A very good example of what I would call a dappled eruption occurred to me in a person who was sent to me by Mr. Coalbank, Teddington, for diagnosis. The whole of his chest and abdomen and fronts of his arms were congested, the congestion being arranged in such a manner as to inclose ill-defined paler spots, and to produce an appearance exactly similar to the skin some time after death, or to the dappling on a grey horse. There was not the slightest thickening of the skin, nor any approach to papules. The state came nearest to a roseola, but in reality there were no patches of redness or tufts of vessels, like those seen in measles. It was a dusky red surface with ill-defined paler spots on it. The diagnosis as to the cause of this condition was somewhat difficult. I should certainly have taken it for the first stage

* I find it difficult in dictionaries to distinguish between "dappled" and "mottled." The condition of "dappling," as I define it, is beautifully shown in portrait No. 68 of Neumann's Atlas of Skin Diseases, just published under the name "Leukoderma Syphiliticum."

of a syphilitic exanthem, and should have supposed that it had not been present more than a few days, and would soon give place to some other more definite form of eruption. The patient asserted, however, that it had been out for six weeks, and the evidence as to syphilis was doubtful. He had had an attack of gonorrhœa three months ago, and with it some very transitory excoriations. His frenum had been torn. During the last fortnight he had had a slight sore throat. His throat, however, showed nothing but general congestion. The most suspicious fact was a very definite enlargement of his inguinal glands.

Jan. 28.—The rash has much faded in the fortnight, and has quite left his arms. There are superficial ulcers on the tonsils which are very suspicious. For these we order chlorate of potash, and still defer specifics.

Feb. 12.—As yet we have given no mercury, and it is just a month since the first note. The rash, although less definite, still remains, and is of just the same character that it was. It is a sort of mottled erythema, and occurs only on chest and abdomen. It might be easily overlooked or supposed to be only a normal condition. It is indeed only an exaggeration of the mottling often seen in healthy persons. It increases somewhat if he remains naked. His throat under chlorate of potash is better as regards ulceration, but the tonsils are still large and he complains that they feel stiff. The inguinal glands are enlarged and very hard on both sides. I now advise that mercury should be given, being convinced that we have to do with the secondary stage of syphilis.

No. XXVIII.—*Unusual and persisting eruption in the secondary stage of Syphilis.*

A patient whom I saw with Dr. Lichtenberg presented a very unusual form of eruption after syphilis which remarkably resisted treatment. He was a man of the age of 34. His sore was contracted on the 6th of September, 1887, and became indurated. In October he had roseola, and an eruption on his back, which Dr. Lichtenberg described as looking like vibices. In February the eruption was increased

and he had an ulcer on his velum. Inunction of mercury was now substituted for a mixed mercury and iodide treatment which he had had before. During the summer of 1888 he was in Berlin and had sore throat on and off, and his eruption, in spite of treatment, still persisted. On October the 10th, that is one year after the commencement of the eruption, he was sent to me, the reason for the consultation being that the eruption still remained out. He had been salivated to a slight extent, and was so when he came to me. The eruption was very peculiar; it occurred chiefly on his shoulders and upper part of back, but to a slight extent also on his chest and thighs. It was in long oval patches and streaks, of a dusky brown tint, and gave him exactly the appearance as if he had been flogged. Some of the patches were polished and crinkly. We gave him more mercury with iodide in combination, but a month later his condition was almost the same, as will be seen by the following note. After this the three iodides were given together in still larger dose, and in combination with the bichloride. During the whole of this period he had no other symptoms whatever, and was in excellent health.

Nov. 27.—The stains are still present in long coffee-brown streaks on his back, and in patches more or less rounded on his arms, fore-arms and thighs. He says that they are not new, but relapses of the original ones. New ones, he says, come and go: those in the back persist. The newer ones are slightly scaly and rough; those on his back are becoming slightly polished. They itch a little. They are arranged much like the brown streaks in Leprosy as shown in Danielson and Boeck's atlas, or their portrait of "Psoriasis." He is in excellent health, and has no other syphilitic symptoms. He has taken mercury freely, and kept the mouth a little sore. He says that a few applications of the ointment easily remove the spots for a time.

On May 13th, 1889, he again presented himself. He considered himself quite well excepting the stains, and during the last months no fresh spots had appeared. None of the patches were at this date in the least scaly. Although much less conspicuous than formerly, they were still easily seen.

The following note was taken: "The patches are now only glossy stains. He takes Turkish baths, which remove the epidermis from the intervening skin, and leave the stains the more conspicuous. The latter are brownish, and quite smooth and glossy in their surfaces (like the true Lichen-Ruber). They are easily distinguished on looking obliquely over the back, by their shining surfaces. They are in streaks and ovals, and his back and shoulders look as if he had been flogged."

MISCELLANEOUS NOTES.

No. I.—*Typhoid Fever not fatal in children.*

It is a very remarkable fact for the student of the exanthemata that typhus fever is scarcely ever fatal in children. Dr. Grimshaw, in his evidence before the Vaccination Commission, said, "I never saw a young child die of typhus fever, and I have seen thousands of cases."

No. II.—*Swelling of the Face from Copaiba.*

A gentleman who had been taking oil of sandal-wood capsules for two weeks without ill effects, changed them for copaiba, with the result that his face and eyelids swelled up directly, "as if I had erysipelas." It declined quickly when the drug was left off, but the conjunctivæ remained watery. He had no eruption on the body.

No. III.—*Result of Amputation of whole hand, with the exception of the thumb.*

A navvy, aged about 50, had his left hand amputated (leaving carpal bones) four years ago. When I examined his hand the thumb had good movements and strength. He said, however, that he would rather be without his thumb, as it caught against things in his shovelling work when he had his artificial hook-hand on. On the whole he decidedly considered that the thumb was in his way. With better mechanism and in other employments it might perhaps have been made more useful, but as it was he did not consider conservative surgery a benefit.

A CATECHISM OF SURGERY; WITH CASES FOR DIAGNOSIS.

No. XXIX.—*On Reproduction.*

1. Define the terms "gamo-genetic" and "agamo-genetic."
2. What is meant by conjugation in a biological sense?
3. Is the impregnation of the ovum effected by the entrance of a single spermatozoon, or of several?
4. What is meant by the term "spermatogenesis"?
5. What is the process which in the female corresponds with spermatogenesis in the male named?
6. What are the chief phenomena of ovulation?

ANSWERS.

1. Gamo-genetic (=sexual reproduction) refers to impregnation and the results of admixture of protoplasm from two distinct sources or individuals. Agamo-genetic (=a-sexual reproduction) is applied to multiplication of individuals from a single parent, without marriage or sexual admixture. It has been well called "simply discontinuous growth."

2. It is the simplest form of sexual generation, and consists in the coalescence of two similar masses of protoplasmic matter derived from different parts of the same organism, or from two organisms of the same species.

3. It is believed that as a rule, with very few exceptions, only a single spermatozoon enters the ovum. If two or more force their passage, the result is probably a monstrous development.

4. The production, by the testis, of the male element or semen. The essential constituents of semen are the spermatozoa. The function of spermatogenesis is not taken up until

the animal has attained a certain age; it varies much at different periods of life and under different circumstances, and diminishes in activity as age advances. Its commencement is marked by important changes in the whole organism, which are denoted in their aggregate by the term puberty.

5. It is called ovulation. Puberty in the female is the period at which *ovulation* commences, and it is usually denoted by the occurrence of menstruation.

6. Congestion and growth take place in certain parts of the ovary (follicles or ovum-capsules), and as a result the ovum ripens and is expelled. Its expulsion is attended by intense congestion and hæmorrhage (menstruation). After expulsion, the cavity, which contains blood-clot, contracts, and a "corpus luteum" results.

No. XXX.—*On Generation and Impregnation.*

1. Distinguish between generation and impregnation.
2. How are drones, working bees, and queen bees respectively produced, and in what do they differ?
3. Can the workers (females in suppression) ever produce eggs?

ANSWERS.

1. Generation is effected whenever a new individual organism is produced, and may be wholly independent of impregnation. In the words of Huxley, "Generation may be regarded as a particular case of cell-multiplication, and impregnation simply as one of the many conditions which may determine or affect that process." Or again, impregnation is the physical admixture of protoplasmic matter derived from two sources, which may be either different parts of the same organism, or of different organisms.

2. The drones are male bees, and are produced from eggs which have not been impregnated; the workers are females, and are from impregnated eggs; the queen is a worker whose development has been increased and specialized by the liberal supply of a particular kind of food. Drones never show any tendency to collect honey; workers collect honey, but produce no eggs; the queens do not collect, but produce eggs. It is

a mistake to call the workers "neuters," for their sex is only suppressed, and they are undoubtedly females.

3. Yes; occasionally a worker is fertile and may lay eggs. They are, however, never susceptible of impregnation; and their eggs produce only drones.

No. XXXI.—*On Fractures near the neck of Humerus.*

1. When the neck of the humerus is broken in elderly persons, what is the usual position of the fracture?

2. Distinguish between the surgical neck, the anatomical neck, and the line of the epiphysis respectively.

3. What may we infer from the conditions met with in such fractures in old persons?

4. What is the usual displacement in such cases?

ANSWERS.

1. The line of fracture is often oblique, or in parts spiral. Thus it may come close to the head behind, and be low in the surgical neck in front. It is often attended with comminution, and it is very rarely cleanly transverse.

2. The surgical neck is that part of the bone well below the tuberosities, where it is narrowed down to little more than the size of the shaft. The anatomical neck may be marked by a line drawn round the bone, close below its articular head. The line of junction of the epiphysis is between these, and would leave the two tuberosities still attached to the head.

3. The line of breakage being irregular in its course, and not keeping either to the anatomical or surgical neck, its occurrence indicates that the bone has undergone some senile atrophy and become somewhat brittle. In a younger and stronger bone the same kind of violence would probably have produced a dislocation, or a more near approach to a transverse fracture. At any age under puberty the lesion produced would probably be a detachment of epiphysis.

4. The displacement is often but slight. Its chief feature is a drawing towards the chest of the upper end of the lower fragment.

No. XXXII.—*On Amputations of the Foot.*

1. What is a Chopart's amputation?
2. What are the supposed disadvantages of a Chopart's stump?
3. For what cases is a Chopart applicable? What is the usual alternative?
4. In what does a "Syme" differ from a "Pirogoff"?
5. What cases are suited for Syme's amputation?
6. What points require special attention in the performance of a "Syme"?
7. What are the objections to a "Pirogoff," and what its advantages?

ANSWERS.

1. Removal of the foot, leaving only the os calcis and astragalus.
2. It takes away the front support of the arch of the instep, and it is often followed by retraction of the heel.
4. In Syme the whole foot is removed at the ankle, whereas in Pirogoff the posterior third of the os calcis is left, and turned up into apposition with the tibia.
5. All cases of disease or injury of the foot, or of the ankle joint, in which the heel is uninjured.
6. Care must be taken not to cut the posterior tibial too high, and also not to jag or score the heel flap.
7. A Pirogoff, in addition to the risk that the part of the os calcis which is left may be displaced backwards, makes, even in the best cases, a stump which is too long to be convenient.

No. XXXIII.—*On Gall-stones and Obstruction of the Bowels.*

1. In what way may gall-stones simulate obstruction of the bowels, and in what way may they really produce it?
2. Are cases of hepatic colic always attended by jaundice?
3. How would you treat a case in which you had diagnosed a gall-stone in the cystic or hepatic duct?
4. How would you treat a case in which you diagnosed a gall-stone impacted in the bowel?

5. Is it possible for a large stone, say as thick as one's thumb, to escape from the gall-bladder without ulceration?

ANSWERS.

1. A gall-stone impacted in the cystic or common duct may, by the pain and sickness caused, simulate acute obstruction, and the more easily because temporary constipation always attends the attack. A gall-stone which has passed the ducts may, if very large, become impacted in the intestine and produce real obstruction.

2. No; if the stone be in the cystic duct, no jaundice will occur. If in the common duct, the production of jaundice will still be a question of time, and the symptoms must not be expected in recent or short cases.

3. The indications are to relieve spasm and pain, and thus favour the passage of the stone. Probably the use of anæsthetics to full insensibility is the most hopeful measure. Afterwards morphia may be given, or the anæsthetic may be long continued or repeated at intervals if the pain persists.

4. If a stone be impacted in the bowel anæsthetics should be used, and large enemata should be given (in the hope that the fluid may pass the ilio-cæcal valve).

5. Yes; the duct is capable of great dilatation, and may allow very large stones to pass with but little suffering.

No. XXXIV.—*On Hernia.*

1. What forms of hernia are often present at birth or in infancy?

2. To what forms of hernia is the female sex most liable?

3. What is the commonest form of hernia in men?

4. How would you distinguish a congenital from a non-congenital hernia (of the inguinal form)?

5. How would you distinguish between a femoral and an inguinal hernia in a case of difficulty?

6. State the anatomical differences between a direct and oblique inguinal hernia?

7. By what rule do you hope to avoid hæmorrhage in dividing the stricture of an inguinal hernia? By what in the case of femoral?

8. What is the cause of risk of bleeding in a femoral hernia?

ANSWERS.

1. Inguinal in male children; umbilical in those of both sexes.

2. Femoral and umbilical.

3. Oblique inguinal, but femoral is also not infrequent.

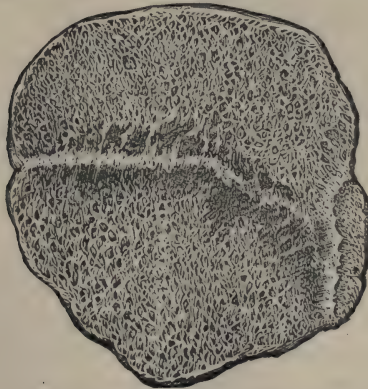
4. By the position of the testis in relation to the contents of the sac. It is concealed behind and amongst the contents in congenital; pushed down to the bottom of scrotum in non-congenital.

5. By passing the finger up the cord, and ascertaining whether or not the inguinal canal was free.

6. A direct hernia passes through the external ring, tearing or stretching the conjoined tendon, whilst an oblique passes through the inner ring in front of the tendon. A direct hernia has the epigastric vessels on its outer side, and an indirect on its inner side.

7. By cutting directly upwards, and as cautiously as possible. By dividing as little as possible, preferring to make several small notches rather than one free one.

8. If the obturator artery is given off from the external iliac or epigastric, it may curve directly over the neck of the sac.

No. XXXV.—*Fracture of Patella.*

Describe the appearances presented in the woodcut.

1. Can you infer anything as to the probable nature of the accident?
2. Is bony union of a fractured patella frequent?
3. On what circumstances does the prospect of bony union chiefly depend?

ANSWERS.

1. The specimen shows complete bony union of a transverse fracture of the patella. The fragments are of nearly equal size. On one side a small portion has been detached, a feature which suggests that probably the fracture was not one due solely to muscular violence. [History not known.] Probably a blow was received when the knee was bent and the bone fixed. Hence it is mainly a "transverse" but in part a "starred" fracture. Probably there was never much separation of the fragments.

2. Bony union is the rule in all starred fractures, and it is not uncommon in those caused by muscular contraction.

3. The wide separation of the fragments in the first instance, and the amount of subsequent effusion into the joint, are the chief influences in preventing bony union.

No. XXXVI.—*Ankylostomiasis*.

1. What is the nature of the disease known as Ankylostomiasis, or Tropical Chlorosis?

2. Who was its discoverer, and in what countries has this worm been identified?

3. Is the disease of interest to British practitioners?

4. What proportion of the Egyptian population is supposed to suffer? What other names has the disease received?

5. What is the possible source of the parasite?

ANSWERS.

1. The disease resulting from the presence of the ankylostomum duodenale in the intestine of man. The symptoms are those of anæmia with rapid œdema, which may end fatally, or, on the other hand, may clear up quickly. The worm is a nematoid, and probably gains access to the body in foul water. A number of worms are found attached to

the mucous membrane of the duodenum, the place of each being marked by a lenticular ecchymosis.

2. Dubini of Milan was its discoverer. He found it in five per cent. of his autopsies. It was very fatal to the workmen in the St. Gothard Tunnel, and has been found in Egypt, in Ireland, and many other places. Dr. Kynsey believes that what is called Beriberi in Ceylon is identical with Ankylostomiasis. Dr. Beaven Rake has found it in two autopsies at the Leper Hospital, Trinidad.

3. It is very possible that unrecognized cases occur occasionally in English practice.

4. Egyptian Chlorosis, or Tropical Chlorosis, are other names for the same disease. The worm is said to be present in one-fourth of the whole population in Egypt.

5. It may be a development of the *Dochmius Trigonocephalus* of the dog.

No. XXXVII.—*Destruction of one Kidney.*



The above woodcut shows the bladder, kidneys and spleen of a dog.

Explain the conditions.

ANSWER.

The bladder contains two calculi of considerable size. The left ureter is much dilated, and the left kidney is converted into a cyst. The other kidney is healthy. No doubt the calculi had originated in the left kidney and travelled down its ureter, causing the destruction of the organ and dilation of the ureter. The bladder is thickened.

COMMENTS.

The specimen is of interest as illustrating one of the conditions under which single kidney may be produced. So far as excretion of urea was concerned, the animal was clearly dependent solely upon the right kidney. Had the ureter of this organ chanced to become blocked by a calculus, death from uræmic poisoning would have ensued.

Calculi are rare in the lower animals.

No. XXXVIII. — *On the use of the term*
“Catarrhal.”

1. To what class of maladies ought the term “catarrhal” to be restricted?
2. What is their mode of origin?
3. Are all inflammations of mucus surfaces attended by discharge properly called “catarrhal”?
4. Are catarrhal affections contagious?
5. Are the domestic animals liable to catarrh?
6. Do catarrhal affections observe stages?

ANSWERS.

1. To those of which an ordinary “cold in the head” or “sore throat from catching cold” are the types.
2. They are produced by reflex disturbance of function and nutrition through the nervous system. Thus wet feet may cause sore throat, or a draught of cold air on the back may induce inflammation of the Schneiderian membrane.
3. When such maladies as chronic cystitis, or metritis, or otitis, are called “catarrhal,” a good word is worse than wasted in misapplication. Such maladies are of a wholly different nature from the true catarrhs, and are due to wholly different causes.

4. It is highly probable, or perhaps certain, that the products of a catarrhal inflammation may become the means of communicating the like disease by contagion to others.

5. Most of our domestic animals appear to be very liable to catarrhal affections. Their catarrhs are probably communicable to the human subject.

6. All true catarrhs being of neurotic origin, observe stages and show a tendency to subside spontaneously after a certain duration.

No. XXXIX.—*On Catarrhal Affections.*

1. Are there exceptions to the statement that all true catarrhal affections tend to subside spontaneously?

2. Does one attack of catarrh in any degree prevent another?

3. What catarrhal affections are dangerous to life?

4. What other catarrhal affections may we recognize apart from those of the nose and throat?

5. What are the principles of treatment in catarrhal affections?

[See ARCHIVES, Vol. I. p. 307.]

ANSWERS.

1. All catarrhal affections show a tendency to spontaneous cure after a week or ten days. In some exceptional cases, however, recovery is not completed, and the disease may lapse into a chronic form.

2. One attack undoubtedly gives protection for a time, but the periods of immunity vary very much and may be exceedingly short. During the early stages of convalescence there is often great susceptibility, and unless the causes are avoided, relapses may easily occur.

3. Catarrhal pneumonia and catarrhal laryngitis are very dangerous affections unless properly treated.

4. We recognize catarrhal pleurisy, peritonitis, enteritis, &c. Probably all the viscera and all the serous cavities may be affected through the reflex influence of cold. Certain forms of rheumatism are probably catarrhal synovitis.

5. The indications are, to restore, as promptly as possible,

the disturbed balance of the nervous system (primary), and of the circulation (secondary). Warmth to the whole surface, heat to the feet, scrupulous exemption from exposure, are the chief indications. Diaphoretics and stimulants which tend to relax the peripheral arteries (alcohol, &c.) should be given. There are a great number of popular methods of cure based on these indications.

No. XL.—*On Catarrhal Affections.*

1. What is the distinction between coryza and catarrh?
2. Does constitutional disturbance attend a true catarrh?
3. Ought we to distinguish between an inflammation induced by the direct influence of exposure to cold and a true catarrh?
4. Give instances of inflammations due to direct exposure of the part to cold.
5. Are the phenomena of true catarrh always symmetrical?
6. Are there any apparent exceptions to the law of bilateral symmetry in catarrhal affections?

ANSWERS.

1. The term "coryza" is applicable to the symptoms of Schneiderian inflammation (sneezing, mucous discharge, &c.) which attend catarrh when the head is affected. Coryza is the name for the commonest symptom of true catarrh, the latter the name for the whole illness.

2. Yes, invariably. A catarrh is a brief nervous fever preceded by a rigor and attended by increase of temperatures, great sense of chilliness, and much general discomfort.

3. Yes, a true catarrh is always due to reflex disturbance, and never to any cause of irritation applied directly.

4. Exposure to cold wind may induce otitis or ophthalmia. Affections so produced are usually on one side only; they may cause constitutional disturbance, but are not preceded by it. They show no tendency to observe stages or to subside spontaneously. Chilblains and frost-bites are examples of inflammations due to direct exposure to cold.

5. The phenomena of true catarrh are always symmetrical, *i.e.*, bilateral.

6. In the case of double organs such as the lungs and kidneys, one may be much more severely affected than the other, and the disease may thus appear to be onesided.

No. XLI.—*Lactation and Conception.*

1. In the human subject does lactation always prevent conception?

2. What evidence do we obtain on this point from observations on the domestic animals?

3. By what measures has it been sought to prolong milk-giving in cows?

4. In spite of the facts above mentioned, is there still reason to believe that prolonged lactation in women has on the whole a tendency to prevent conception?

ANSWERS.

1. It is quite certain that lactation does not prevent fecundation. Many women become pregnant whilst suckling. Dr. Robertson, Dr. Laycock, and others, have collected statistics proving the frequency of this.

2. A rabbit may be impregnated within a few days of delivery. Farmers expect their cows to bear a calf a year and to give milk eight months. Under this arrangement, pregnancy must commence nearly six months before lactation ceases.

3. The attempt has been made, by the removal of the ovaries soon after parturition, to convert the cow into a milk-giving animal only, and thus secure an indefinite prolongation of the lactation period. Sufficient success has, I believe, attended the experiments to warrant the belief that ovarian activity is the chief agent in arresting mammary secretion. There is, however, great risk of spoiling a good cow and obtaining only a partial result.

4. It is a well-established fact that in the human subject lactation, as a rule, prevents menstruation. This gives strong support to the general belief amongst women that it also tends to prevent conception.

No. XLII.—*Case for Diagnosis.*

The following is a contemporary abstract given in the *Medico-Chirurgical Review* of 1843:—

“M. Huguier relates a case of that rare occurrence, *spontaneous gangrene of the surface* in a child, aged $7\frac{1}{2}$ years. The previous history of the patient was unknown, beyond his own statement, that two months before he had had a very violent cold. When received into the Charité, the tips of all the fingers of the left hand were black, and those of the right hand had begun to show a darkish colour. All the toes of the left foot were quite black, the middle toe had dropped off, and the tips of the toes of the right foot were also black. There was neither pain nor redness in the course of the arteries, nor were they less yielding and elastic than natural. The child was bled twice, and took opium during his stay in the hospital; the duration of which, as well as many other points of importance in the case, are not stated. He left the hospital well, having lost all the toes of both feet, the fingers of the left hand, and the whole of the right hand, as also the skin at the tip of the nose, at the prominence of the cheek-bones, the chin, and the edges of the ears.” (“Clinique des Hôpitaux des Enfants,” December, 1842.)

1. Is the expression “spontaneous gangrene of the surface” a correct description?
2. What name would now be applied to the disease described?
3. How is it to be distinguished from frost-bite?
4. What are its causes?

ANSWERS.

1. No; for it is not proved to have been spontaneous, and was probably not so; and it certainly was of the extremities as contrasted with the surface. The chin, the tip of nose and the ears, must all be classed as “extremities.”

2. The case is one of Symmetrical Gangrene of the Extremities, or Asphyxia of the Extremities, now often spoken of as Raynaud’s disease.

3. As an example of Raynaud’s disease it is of uncommon severity, and it is to be diagnosed from frost-bite chiefly by

the absence of exposure to extreme cold and of any preceding stage at all approaching to congelation. The parts affected are precisely those which might have suffered in frost-bite. No doubt it was a case of what might be called "cold-bite" in a very susceptible individual.

4. The causes of Raynaud's symptoms are augmented reflex susceptibility of the arterial system to the influence of cold. This may be in part a congenital peculiarity. It may have been developed or increased by the influence of malaria, by undue exposure to cold or other depressant; by some severe illness. In the above instance it is probable that a delicate underfed child had, after a severe catarrhal illness, been very inadequately protected from the prolonged influence of cold (not actual frost).

No. XLIII.—*Osteitis Deformans.*

1. Distinguish between Osteitis deformans (Paget's disease) and Arthritis deformans.
2. What are the most prominent features of Osteitis deformans?
3. What are the conditions of its pathological anatomy?
4. Are other structures than the bones ever affected?
5. Has it any connection with syphilis or gout or cancer?
6. What is the prognosis?
7. At what age does it occur?

ANSWERS.

1. They are wholly different maladies. The one is a joint disease, a form of chronic rheumatism; the other, a very peculiar affection of the osseous system, having probably no association with arthritic maladies.

2. The patient loses stature owing to softening and bending of his bones generally, and his head enlarges so that he needs larger hats. His skull and long bones are found to be enlarged in a more or less even or fusiform manner.

3. On dissection, the bones are found to be enlarged by great overgrowth of a soft porous structure. On the long bones there is more or less appearance of encrustation, but this is not usually very definite. The enlargements are

usually on both sides of the body and in all limbs, but they are rarely quite symmetrical.

4. The patients sometimes become more or less deaf and blind. In the eye, choroiditis may be found.

5. It has no connection with syphilis, and probably none with acquired gout. Its subjects often die of cancer.

6. It is a disease of extremely slow progress, and is attended by but little failure of general health.

7. The disease never begins in the young, and usually not till past middle life.

No. XLIV.—*Essential Phthisis Bulbi.*

1. What is meant by the term "Essential phthisis bulbi"?
2. Describe its features.
3. What are its supposed causes?
4. Are its conditions constant, or variable?

ANSWERS.

1. This quaint term, which might perhaps be suitably translated "primary softening of the eyeball," was applied by Von Graefe to certain rare cases in which, without obvious cause, the tension of the eye becomes suddenly and greatly reduced.

2. No pathological change is to be detected (as is the case in the numerous cases in which "phthisis bulbi" is secondary to inflammation). The eyeball becomes more or less squared by the pressure of the recti, and the cornea a little hazy by wrinkling of the membrane of Descemet. Neuralgic pains are usual. The tension may be suddenly recovered and then again suddenly fail. There may be opacities in the vitreous. Very few cases are on record, and some of these not quite characteristic.

3. It has chiefly been noticed after injuries near to the eye or operations upon it.

4. It scarcely deserves to rank as a disease, and is probably always a symptom of disease of the vitreous, or of replacement of part of it by serous fluid capable of rapid changes in amount. Its phenomena are, however, worthy of very careful examination.

[Consult "Archiv f. Ophth." xii. 2, p. 256; *Dublin Quarterly Journal of Medical Science* (Swanzy), vol. xlviii. p. 531.]

ARCHIVES OF SURGERY.

JANUARY, 1891.

A VISIT TO EDINBURGH.

HAVING been honoured by an invitation to give the opening address at the Royal Medical Society of Edinburgh (on Oct. 24th), I availed myself of the opportunity to renew acquaintance with the renowned museums of the northern metropolis, and to pay one or two hasty visits to the Infirmary. Through the kindness of numerous friends, who spared no trouble in bringing under my notice subjects of interest, I was enabled to see much in a short time, and it may possibly prove of interest to my readers if I venture briefly to record what has chiefly impressed my memory.

The chief museums of Edinburgh are, first, that of the University, now located in a new building of splendid size and proportions, and recently rearranged under the guidance of Sir William Turner. This museum includes all branches of anatomy and pathology, comparative as well as human. Next we have that of the College of Surgeons, a very large collection of historic repute, and well kept up under the zealous conservancy of Dr. Cathcart. In addition to these public collections, most of the hospital surgeons have their own half-private ones in the Infirmary building, which are used for the illustration of their lectures. That of Mr. Chiene, the Professor of Surgery, in particular is full of most valuable specimens, and is kept in beautiful order. It may be thought that these personal collections must compete injuriously with

that of the University, and so no doubt they do to some extent, just as our hospital museums in London compete with the Hunterian collection.

Mr. Annandale possesses in his private collection a series, of unique value, of specimens of complicated fractures into the elbow joint. These accidents are of course common, and we often have to examine elbows in the living subject more or less crippled by old injuries. It is often exceedingly difficult to determine what the precise character of the displacement or fracture has been. If two surgeons examine the same case they scarcely ever agree as to details, and often differ widely. Almost always they are examples of fracture and dislocation together. Although so frequent in practice, however, it is very seldom that we get opportunities for dissecting such joints, and few of our museums boast more than one or two specimens. Mr. Annandale has a dozen, and most interesting and valuable they are. They have been obtained by excisions performed during life, Mr. Annandale believing that the movable joint obtained after an excision is an improvement on the stiffened one previously present. Most surgeons have reserved excision for cases in which the malposition is very great—such, for instance, as those in which the elbow cannot be bent—and have feared the weakening of the arm which but too often follows an excision. Of this risk Mr. Annandale speaks very lightly. He assured me that his results had been most satisfactory. In all cases he had removed the elbow with the parts *in situ*, and tolerably freely as regards length; so that his specimens, now dried with the ligaments remaining, permit of an accurate appreciation of the exact condition. The collection will, I trust, sometime be described in detail. I had only a few minutes' inspection of it, and can say little more than that it appeared to contain examples of almost all possible combinations of displacement of the ends of the three bones concerned. In only one did the specimen show separation of the epiphysis; in all the others the bones were those of adults. I was particularly interested in noting that in one or more the external condyle had been broken off and carried backwards with the head of the radius, thus permitting of a

dislocation of the latter while not exposing its cup. I have recognized this condition several times in the living subject.

Mr. Annandale showed me also many casts illustrating congenital deformities of the hands and feet. In this subject, as is well known, he has taken especial interest, and some of his family histories are of great value as proving the hereditary tendency to deformities of special kinds. He told me that in one instance he operated for the same defect more than twenty times on members of the same family.

The taste for collecting historic relics appears, I think, to be stronger in our Edinburgh *confrères* than it is with us. The boiler in which Hunter is believed to have boiled the bones of the giant O'Brian has recently found its way from Kensington, not to our Hunterian Museum, where the skeleton is, but to Professor Chiene's private collection. It is highly prized. Mr. Chiene possesses also one of Hunter's drawing-room chairs and various other interesting relics of a man of whom Scotland and England are equally proud. Sir W. Turner still uses every day in his anatomical theatre the slate table upon which Monro primus used to place his subjects for demonstration. It is a massive table, well fitted with movable joints, &c., and although chipped and showing results of wear, is in good condition. It is certainly a relic much to be valued. Some of the objects prized are, however, of rather ghastly interest. The skeleton of Burke is still shown with pride to all strangers. I am not unaware that in Lincoln's Inn Fields we have the skull of Eugene Aram, and may own that I should be glad if it, as well as Burke's skeleton, were relegated to private closets. I could find no scientific interest in the latter, excepting that it is clear that he was not a man of coarse build. His bones are, indeed, exceptionally well formed and light. He had been, I believe, a gentleman's servant. A distinguished Edinburgh surgeon is said to possess a pocket-book made of his 'skin, and the authorities of the University Museum are credited with the ambition of, at some future time (distant it is to be hoped), securing this valuable relic as a bequest to their collection. May it perish first! There is in the Bristol Infirmary Museum a book bound in the skin—the "*cutis vera*"—of a

poor country lout who threw a stone at his sweetheart when she was walking with some one else, and had the misfortune to cause osteitis and death. He was, as a matter of course sixty years ago, hung. It scarcely followed as a matter of course even in those days, I hope, that his skeleton and skin should have been preserved as curiosities in a scientific collection. The skull of the poor girl, which is kept side by side with his own, is of real pathological interest, but from his no ingenuity whatever can extract a lesson. Such objects as the skeletons of murderers, &c., if they must be kept, should be under the curator's lock and key, and not exposed to public gaze. They gratify only morbid curiosity, and tend to distract attention from things better worthy of notice. I cannot but think that they tend to degrade the collections in which they are found.

The above remarks, of course, do not apply to the collection of the skulls or bones of remarkable individuals, whether criminal or not, where they can be made use of for scientific observation as to development, form, capacity, &c. It is, however, I suspect, but very seldom that such purposes can be served, and even when they can I am not sure that the relics which illustrate them had not better be kept in privacy. This leads me to speak of a valuable and extensive collection of casts of heads made by a society which called itself by the name of Phrenological, and under the direction, I believe, of the late Dr. Andrew Coombe. This collection has been placed in the custody of Sir William Turner, and now occupies a room in the University Museum. It contains casts of the heads of a great number of distinguished persons, and has evidently been collected with great expense and trouble. If all the casts are authentic, it is of great value for the study of physiognomy in reference to character, and deserves to be better known than it is. I had not time to examine it in any detail.

Amongst the most recent of the specimens added to his collection, Professor Chiene showed me a coccyx and part of the sacrum which had been excised in order to facilitate removal of the lower part of the rectum for cancer. He spoke most strongly of the advantages secured by removing the bone, and also of the general result of his cases. He

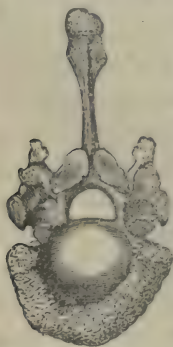
had had difficulty, he said, once from hæmorrhage from the middle sacral, and in future purposed to tie it before division. He urged close adherence to the mode of procedure advised by the originator, and said that he had reason to regret having tried to improve upon it.

I visited the Museum of the University first in company with Sir William Turner, who kindly devoted several hours to showing me its treasures, and on a second occasion with Dr. A. Thomson, the sub-curator. Amongst its specimens which have become historic is that of a dog, all of whose bones have been affected by encrusting periostitis. It is certainly most valuable and important. Dr. Hughes Bennett used to employ it as an illustration of the injurious effects of mercury, for the dog belonged to an artist, and it was said that it had been in the habit of licking paints, in the studio, which contained mercury. That the conditions exhibited by the bones had anything to do with mercurial influence is very doubtful. The bones, especially the long ones, show thick layers of spongy growth beneath the periosteum, enlarging the shaft to two or three times its normal size. There is neither caries nor necrosis. A leg bone shown in sections proves that the encrusting layer enclosed the original bone, of course adhering to it, but not causing other changes in it. Thus it does not resemble what is met with in osteitis deformans, or in acromegaly. It might seem that this encrusting or ensheathing form of multiple periostitis is more common in the lower animals than in man. At any rate, all the best examples of it are in the bones of animals or birds. Our College of Surgeons Museum contains several specimens in birds (barn-door fowls, I think), and in the Brighton Museum is the thigh bone of a turkey similarly ensheathed. Sir W. Turner drew my attention to a most remarkable example of it affecting one of the tail vertebræ of a whale. No information was extant as to the state of the other bones of the skeleton. The specimen had been rescued by Sir William from a bone-crusher's establishment, and no others like it could be found. The body of the vertebra was thickly covered in all parts by a growth of new bone, which was of almost uniform thickness in all parts and nearly doubled

its bulk. The new bone adhered inseparably, and presented a roughened surface. The enclosed body appeared to be quite healthy. To suggest that it was a form of rheumatic osteitis from prolonged exposure to damp and cold was easy, but did not help our doctrinal pathology much. Another very curious specimen, also obtained by Sir William Turner himself, consists in the horns of a deer encrusted all over with bony outgrowth, much like that on the whale's vertebra. It gave the horns the appearance of a mass of branching coral. The deposit, as in other cases, was of uniform thickness, and very rough on the surface. The bones of the skull from which the horns grew were not affected in any way. Professor Turner told me that he had obtained the animal's head from a friend, and that it was, possibly, that of an animal which had retained its horns owing to castration. The horns when obtained were encased in a very thick integument. The conditions affected the two horns equally, and were clearly not due to injury, nor to any local cause. I cannot but think that the birds' skeletons referred to, that of the dog, the whale's vertebra, and the deer's horns, must all be considered together as examples of a form of osteitis which we do not find at all closely paralleled in the human subject. That any of them have anything to do with mercurial influence becomes improbable in the highest degree when we take them together.*

Whilst on the subject of encrusting periostitis, I ought to

* Just before going to press I have recollected and succeeded in finding a woodcut, which I here reproduce. It is one which I had executed many years ago from a specimen in the Museum of the Royal Veterinary College. It shows exactly the same state as regards encrustation of the body of the vertebra, which is present in Sir William Turner's specimen above described. It will be seen that the whole of the front surface of the body and many parts of the processes are covered with a thick encrustation of new bone. This encrustation did not extend from one vertebra to the other, but left them quite separate. None of the joints appear to have been in any way affected. The bone is certainly from one of the lower animals, and, I think, from a horse; but I am speaking rather at random, having neither the



specimen, nor any reference before me.

mention the calvaria of a negro which presented conditions the like of which I have never before seen. It was covered all over its surface by a thick deposit of new bone, very hard, but pitted and rough on its surface, almost honeycombed. The deposit doubled the thickness of the bone. There was no disease of the under table, and the conditions in the upper were wholly unlike those of syphilis or new growth. The new bone was spread in even thickness over the whole calvaria, with the exception of the sides, where the bone is protected by the temporal muscles. Here there was no change. This abrupt symmetrical limitation suggested that the condition had been caused by some disease of the scalp, or possibly had been a sequel of scalping. The negro had lived in the United States, and might possibly have been in the hands of the Indians. The base of the skull was not preserved, so that the limitation of the changes, back and front, could not be ascertained. It will be of interest to learn whether American observers are familiar with the conditions described. They reminded me a little of those shown in a specimen in the Musée Dupuytren in Paris, in which they are attributed to favus of the scalp.

The Museum is rich in urinary calculi both from India and Scotland, and also contains many specimens of concretions from the intestines of the lower animals, with a few from those of man. Amongst the latter I observed one which had a small plum-stone for its nucleus. It was exactly like one shown me by Professor Virchow a few months ago in Berlin, and mentioned in ARCHIVES, ii., 116. My attention was also drawn to a series of "womb-stones," the calcified remains of fibrous tumours. Two of these were of very large size. One had been obtained from a grave which had been opened long after burial, and after the soft parts of the body had decomposed. It was found in the pelvic cavity, and was presented to the Museum as a specimen of a very large vesical calculus. About its true nature there could of course be no doubt; but after all, I do not think that it was very much larger than a true bladder calculus of enormous size, which was subsequently shown me by Professor Chiene.

Dr. Cathcart has for some time been collecting models and

specimens illustrating the association of certain forms of diffuse osteitis of the long bones with elephantiasis and similar conditions. I am enabled by the accompanying wood-cut, which has been for many years in my possession, and which was originally published in the *British Medical Journal*, to show the condition referred to.

Specimens in all respects similar are preserved in every pathological museum. Unfortunately, however, it is seldom that there is any clinical history connected with them. The



bones are there, but no one can tell from whence they came or with what conditions they were associated during life. It is to the elucidation of this question, and more especially to its full demonstration by models, &c., that Dr. Cathcart has given his attention. He has in two or more cases been able to place a model of the patient's leg side by side with the specimen obtained either after amputation or death. This was exactly what was wanted, and his models are most instructive.

The bones to which I refer usually show the effects of general superficial osteitis, being roughly encrusted with new deposit over their whole surfaces. The interosseous membrane is frequently converted, to a greater or less extent, into bone. In the majority of specimens only the shafts of the bones are involved, but in the worst the morbid changes extend to the articulations.

These specimens show the conditions produced by long-standing solid œdema of the leg, attended by general inflammatory hypertrophy of tissues. They are obtained in England from cases usually of chronic ulceration, persisting for many years and attended by permanent enlargement of the limb. In the worst of these cases, conditions to which all would give the name of elephantiasis are produced; and the minor ones ought to be recognized as earlier stages of the same malady. In the wood-cut given above it will be seen

that on the front of the lower third of the tibia there is an oval-margined surface, which is limited by a raised edge. This in all probability marks the site of an old ulcer. I can give no history of the specimen here figured. It is one in the London Hospital Museum which has been preserved, as so many unfortunately are, without any clinical record. I have several times dissected such limbs and proved the association of the two conditions. Dr. Paul Reclus, in a paper in the *Progrès Médicale*, has recently drawn attention to them.

Amongst the collection of skeletons there are several of great interest in illustration of the various conditions met with in rickety dwarfs. One of these especially claimed my attention on account of its close similarity in many features to the skeleton preserved in the Norwich Museum, which, through the kindness of Mr. Cadge and Mr. Cross, I was enabled to show at the Pathological Society two years ago, and which is known as that of the Norwich dwarf. It will be remembered by those who were present at that meeting that I was inclined to doubt the applicability of the name rickets to that specimen, since it nowhere showed any evidence of bending of the shafts of the bones; and there were very peculiar conditions as regards thickness of bone and exaggeration of the ridges for muscular attachments which are not usually seen in rickets. Mr. Shattock and Mr. R. W. Parker expressed opinions somewhat different, holding that the skeleton did really belong to the category of intra-uterine rickets. Perhaps the real question between us was as to how closely the latter malady is allied to the post-natal disease. I am bound to say that the Edinburgh specimen gives some evidence in support of Messrs. Shattock and Parker's contention, for in addition to dwarfing, and changes in the joint ends of the bones very similar to those in the Norwich dwarf,* it shows curvature of the shafts exactly like those of post-natal rickets. There can be no doubt that its possessor suffered from rickets after birth. As regards the peculiar bevelling off of the sternal extremities of the clavicles which is present in the Norwich specimen, that remains so far as my experience has yet gone, and so far as

* Excellent photographs of the Norwich dwarf have been preserved in the College of Surgeons Museum (London).

I have been able to avail myself of the experience of better osteologists, a quite unique feature.

Amongst the most valuable of the additions which have recently been made to the University Museum is one presented by Dr. Alexis Thomson, the present curator, showing unilateral exostoses from certain bones of the face and skull with also general hyperostosis. I have myself long possessed a skull, to which I have made frequent allusions in print, which I have believed to be a unique example of this condition. Dr. Thompson's specimen is almost the counterpart of my own, and makes the second case; and I have just found in Heuse's Atlas an illustration of a third, which in some features, though by no means in full development, resembles them.

One of the specimens which interested me most in the Museum of the Royal College of Surgeons, was a demonstration of the mode in which melanosis spreads in the lymphatic trunks near to its seat of origin. Dr. Cathcart showed me a beautifully dissected specimen of the lymphatic trunks from the leg of a patient who had a primary melanotic growth on the foot. Scattered all over these subcutaneous trunks, like minute beads threaded on a wire, with irregular intervals of separation, were the little black nodules of secondary growth. They had of course nothing to do with lymphatic glands, but were developed in lymphatic trunks of the smallest size, and these, too, immediately beneath the skin. The preparation showed a whole network of them. I had long been aware that there are certain cases of melanosis in which the growth, during the earlier periods of its secondary reproduction, is, in a remarkable manner, restricted to the limb in which the disease originated. This law of temporary local restriction applies of course not solely to melanosis; it is seen also in certain forms of scirrhous, especially of the breast, in which many nodules are often developed in the skin at a little distance from each other. In epithelial cancer, however, we seldom or never see instances of it, and it is rare in most forms of sarcoma. In most of these latter varieties of new growth the infecting germs usually pass unimpeded through the

PLATE XXVIII.

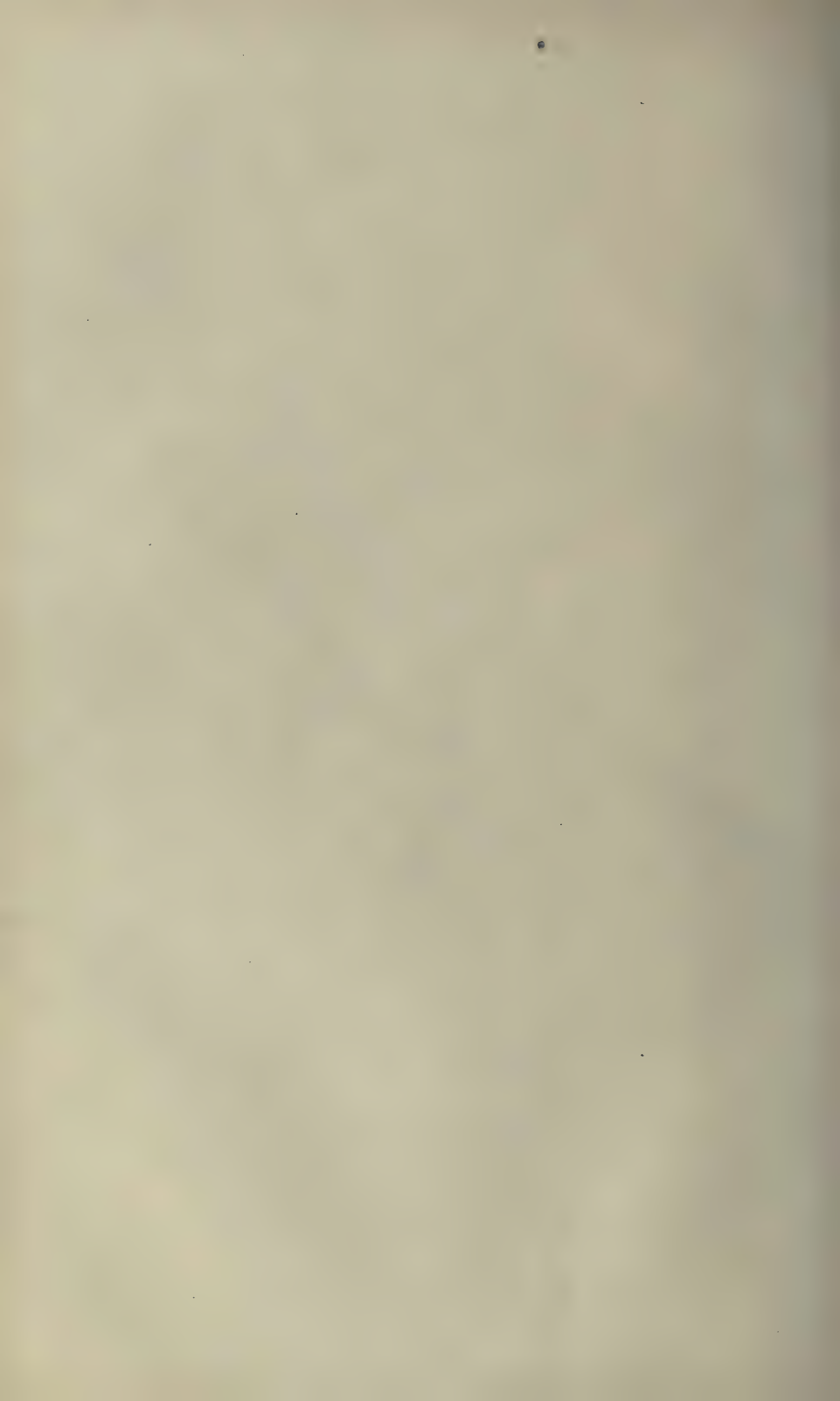
MULTIPLE MELANOTIC GROWTHS IN SKIN, CONFINED TO
THE LIMB IN WHICH THE PRIMARY GROWTH HAD
OCCURRED.

THIS portrait is copied from a drawing given to me by Professor Gairdner, of Glasgow. I am not acquainted with the particulars of the case, for I believe that Dr. Gairdner had never himself seen the patient. It shows a whole crop of little melanotic tubers, like currants or small grapes, in the skin and subcutaneous cellular tissue, of one lower extremity, of an old woman. The primary disease had been, I believe, on the third toe. The portrait is of great interest, as illustrating the tendency in some forms of melanosis to infect in the first instance the lymphatic trunks of the parts adjoining to the primary disease. Thus the first indications of infective spreading are local. To this tendency I have adverted in the text, page 202.

The portrait is almost the exact representation of the leg of another woman, also referred to in the text.

The reader may also with interest look at some of Hebra's illustrations of Melanoid Sarcoma.





lymphatic channels, and are arrested only when they reach the next adjacent glands. Melanosis affords us by far the best examples of what I refer to; and since its growths are black and very conspicuous they easily attract attention. An example of this, which received a good deal of attention from the London profession three or four years ago, occurred in a woman living in Norton Folgate. She had a primary melanotic growth on one foot, I think the right, and the whole of the right leg and part of the thigh became covered with little black nodules from the size of a currant to that of a grape. She was not in any way under my own care, but I was indebted to her medical attendant for an invitation to go and see her, of which I gladly availed myself. Although at first restricted to the lower extremity on which the primary growth occurred, the disease soon after became generalized, and coal-black nodules appeared on the skin of various parts. I believe that she subsequently had hæmoptysis, and no doubt she is long ago dead.* I am fortunate in being able to produce a graphic pictorial illustration of the condition referred to. It is one which also has Scotch associations, for it is copied from a drawing which was very kindly given to me by my friend Professor Gairdner, of Glasgow, when on a visit to the museum there some years ago. It shows the right lower extremity of an old woman covered from the foot upwards with melanotic growths. The primary growth had been on the foot. I am not aware of the sequel of the case; but no doubt it was, as usual, rapid infection of the viscera and of distant parts of the skin, failure of strength, and death. In cases of melanosis beginning in the eyeball, I have more than once had to do second operations on account of recurrence in the cellular tissue of the orbit, and have found not a single mass, but a multitude of little black nodules like small shot scattered amongst the cellular tissue and fat. No doubt in these cases, as in Dr. Cathcart's specimen, had a careful dissection been possible, it might have been demonstrated that the growths had originated in the cavities of lymphatic channels.

* This remarkable case may possibly have been published, but if so I have not come across it.

It is by no means all forms of melanotic sarcoma which manifest this very remarkable tendency to reproduction in adjacent lymphatic trunks. The cases are indeed very exceptional. In a large majority the first secondary manifestation of the disease is in the lymphatic glands, to the entire exemption of the lymphatic trunks. In some the glands themselves escape, and the first proofs of the migration of cell elements occur in internal viscera. Speaking generally and with, I am aware, many exceptions, I think that it is in proportion to the homogenous structure, and utter blackness, of the first growth that the tendency to lymphatic implication becomes marked. At any rate I have never myself seen any case of reproduction of melanotic nodules along lymphatic trunks excepting in cases in which the new material was of a homogeneous structure and black colour. The cases in which melanotic sarcoma, as is usually the case, is in part pigmented and in part not so, are usually attended with large gland growths and exemption of the trunks. This I think may at any rate be laid down as invariably the fact, that the gland growths are never black. I never saw a large gland mass which was wholly or even very extensively pigmented. Probably, however, all these little differences as regards the clinical career of the disease depend upon the exact structure in which the first growth takes its origin. The stamp of peculiarity is derived from the land of birth.

My visits to the wards of the Royal Infirmary were sufficient to enable me to renew former impressions as to the excellence of the methods of clinical instruction there pursued. I saw also many examples of admirable surgery. For the most part, however, my opportunities were too brief to permit of my venturing to record anything as to individual cases. Two or three I will, however, briefly mention.

In Dr. Duncan's wards I was shown a woman past middle age, who was under treatment for general enlargement of lymphatic glands believed to be due to tertiary syphilis. It was an example of the simulation of Hodgkin's disease by syphilis.* The diagnosis of syphilis rested on the presence

* The reader may in connection with this subject refer with interest to a case of Dr. McAll Anderson's, mentioned in the ARCHIVES, i., 72.

of some ulcers on one shoulder which had healed quickly under specifics. There was, I believe, no history to be obtained. The patient was of earthy pallor and thin. Her cervical and axillary glands were on both sides much enlarged, without inflammation. They were not agglutinated, and, being very firm, were easily moved on each other. I was told that they had already, under treatment by specifics, much diminished in size.

Another case of interest was that of a man who had been admitted the day before with a large healing scalp laceration and traumatic tetanus. He had also the complication of facial paralysis on the right side, which in the most remarkable manner interfered with the development of the risus sardonius. His face showed the characteristic grin on one side only. The facial paralysis was probably due to a fissure fracture of the petrous bone, for he was deaf on the same side, and the history was that it had been present from the first. The accident had been a fall, when drunk ("not so very," he interposed), from a wall. He had cut his head on a stone, and the believers in the bacillary origin of tetanus may fairly claim the case as one in which, very probably, earth found its way into the laceration. The symptoms of tetanus had developed about the tenth day, but in spite of this rather long interval they were severe, and the prognosis appeared to be very grave. I was told that tetanus is rare in Edinburgh, and that in the case last preceding there was also a possibility of earth-infection.

Dr. Duncan had also under care a patient whose case is the subject of much interest to his physiological colleagues, since it is believed that all the bile escapes externally from a fistula. The patient is a woman in whom, under conditions of extreme difficulty, owing to adhesions, the gall bladder was opened and explored for calculus. A stone was found blocking the common duct, but it proved impossible to dislodge it. At a second exploration the stone could not be felt, but all the bile has ever since escaped from the fistula. The woman has done well, and her case is—half in earnest and half in joke—asserted to prove that the bile does not serve any useful purpose in the intestine.

(To be continued.)

DOCTRINAL PATHOLOGY.

So large a portion of the pages of the "ARCHIVES" is occupied by case-narratives that I feel almost sure that a section devoted especially to the discussion of pathological doctrines will be acceptable to my readers. In undertaking this, it is wished that it may be fully understood that the design is to discuss rather than to enunciate. I shall endeavour to express as clearly as I can the points under debate, and whilst never seeking to conceal my own opinions, shall be far from desiring that they should be accepted as conclusions. One of the advantages afforded by periodical publication is the facility given for returning to topics already to some extent dealt with, and of re-stating opinions in the light of additional facts or of further thought. Of this I propose to avail myself freely, and not being one of those who hold that it is a duty to maintain in their integrity all opinions that have once found expression, I shall take liberty to express freely the creed of the day, purposing to modify, or even to abandon, in the future whatever may be found no longer tenable.

Is it necessary to take for granted the presence of some form of bacillary or other parasite whenever contagion occurs? The tendency of recent research has certainly been in this direction. We have found the gonococcus for gonorrhœa, and to diphtheria, glanders, erysipelas, anthrax, and many others, a special bacillus has been assigned which is in all probability the agent of contagion. But let us ask, does the fact of contagion always imply parasitism? May not products of inflammation, other than newly-developed and independent organisms, be capable of transferring the

malady from place to place in the patient, or even from person to person? We may probably infer that when diseases keep close to the original type-form, when that which is produced by contagion is exactly like that which existed in the person from whom the contagion was derived, that some parasite giving specificity is present. We may take specificity in result as proof of specificity in cause. It seems to me highly probable, however, that the products of inflammations which have originated from other causes than contagion, easily and at an early stage become contagious.

So far as we at present know the facts, Koch's fluid may probably be taken as a detector of the tubercle-bacillus or of its effects in the past. If there are scrofulous inflammations which are not bacillary, it has probably no influence on them. In it we shall, it may be believed, have a test as to the presence or absence of the parasite. As such it will be invaluable, and may be expected to help to the elucidation of many problems. For my own part I shall be by no means surprised if it should demonstrate that after all tuberculosis is only a sort of accidental addition to scrofulosis. To put the suggestion in other words, it may lead us to attach far greater importance to the previous diathesis and state of health of the patient, and far less to the accidental implantation and growth of the parasite. Every housewife knows that however important it may be to rub away all mould, it is, if the house be damp, hopeless to attempt to get rid of it by such means. It may be just as irrational to think that tuberculosis can be cured by killing the extant crop of the bacillus.

The close similarity of the bacillus of leprosy to that of tubercle has claimed the attention of all observers. Most hold, I believe, that although the differences are slight, they are quite definite; but some, well entitled to form opinions, have thought that our knowledge as yet is not sufficiently explicit to justify this conclusion. That leprosy and the tubercular malady are both of them attended by the presence in large quantities of bacilli, and that these stand in

the relation of cause to some of the phenomena produced, almost all will acknowledge. It may be worth while at the present stage in the investigation of these matters to ask attention to certain parallels and to some conspicuous differences between the two diseases.

Amongst the most noteworthy differences between tubercular maladies and leprosy is the clinical fact that while the former acknowledge very definitely predisposing causes, we know nothing of such in reference to leprosy. Any one, at any age, and without the slightest regard to temperament, inheritance, or state of health, may, on going to reside in a leper-district, become the subject of leprosy. Nor is there in many cases, perhaps in most, any introductory period of ill health.

I am aware that a stage of febrile prodromata has been described by local observers. There is, however, the fallacy that these observations were usually made in unhealthy and malarious districts, and upon patients who might easily be the subjects of other disease. I can bear clear testimony, from the observation of many cases, that no failure of health whatever was noticed before the manifestations of leprosy began. It may also be mentioned as a feature of difference between leprosy and tuberculosis that all cases of the former are chronic. We have nothing in the least comparable with acute tuberculosis. By far the chief fact as to difference between the two is the strict endemic limitations of the one as contrasted with the universal diffusion of the other. If we were to judge from clinical evidence only, we should believe that leprosy must depend upon an absolutely specific cause, and tuberculosis upon a variety of influences which act prejudicially upon the general health.

Whatever may be our creed as to the possibility of inflammation-products becoming contagious without the presence of any parasite, there can be no question as to the converse proposition. Many diseases are attended by specific bacilli and yet do not manifest contagious powers. Even tubercle itself appears to be but very weakly contagious, leprosy not at all so; and concerning tetanus, no one has ever

proved that it is communicated from person to person. We admit our leprosy patients into the open ward, allow them at home to associate with their friends, and although the disease lasts a lifetime and is often attended by free secretion, no accidental contagion ever takes place. Surgeons have, with the utmost zeal, prosecuted investigations into the pathological anatomy of leprosy in thousands of cases, but no post-mortem abrasion, no pricked finger has ever yet resulted in the communication of the disease. As regards tetanus, the facts are yet more free from dispute. It is very important to keep these facts in mind, for one result of Hansen's discovery of the lepra-bacillus has been a wide-spread retrogression to the old belief in the contagious nature of the malady. We cannot too definitely rid our minds of the supposition that because a disease is attended by a specific parasite, it is therefore contagious.

Those who in reference to tubercular maladies attribute most importance to the bacillus, yet admit that predisposing influences take a large share. They by no means ignore the parts taken by hereditary predisposition, narrow chests, feeble tissue-organization, imperfect feeding, exposure to damp, and the like. Seeing then that peculiar states of tissue-health are fully acknowledged quite independently of the specific poisoning, may we not assume that they in themselves are efficient to the production of certain forms of local disease? It may be that a large group of maladies, formerly classed as scrofulous, are the direct results of chronic inflammation in those who are fit subjects for tuberculosis, but have not as yet received the bacillus. Scrofulous ophthalmia and chronic ulcers of the cornea, in feeble persons with thick lips and patchy colouring of cheeks, may stand as examples of these diseases. No one holds that these ulcers are really tuberculous, but they certainly occur to those whose state is such as to render them more prone than others to tuberculous affections. These are examples only of a large group.

In emphasizing the acknowledged truth that feeble

organisms and damaged parts are more prone to be victimised by certain infective agents than those which are strong and sound, we must carefully guard against pushing it beyond the facts. It applies only to some parasitic poisons, and not by any means to all. Syphilis, small-pox, scarlet fever, and the like, wait not in the least for predisposition, but attack all alike. It has even been supposed that the exanthematic fevers are more severe in the strong than the feeble, and it would not be difficult to sustain a similar argument as regards syphilis.

The remarkable facts which already seem to have been proved in reference to the influence of Koch's fluid on "Lupus" will, I hope, have the effect of drawing the attention of pathologists in more detail to the study of the diseases which pass under that name. Lupus is, it may be suggested, not the name for a single malady, but rather for a family. It is by no means a simple equivalent for tuberculosis of the skin. The bacillus, although often found in the true apple-jelly-like growth of common lupus, is more usually not to be demonstrated, and other forms of tuberculosis of the skin have been described which do not resemble "lupus." In the mouth, on the gums, cheeks, palate, &c., true tubercular ulcers differ both in appearance and in clinical course from lupus of the same parts. There is a whole series of affections certainly cognate with common lupus in which, as yet, no bacillus has ever been discovered. In this matter clinical observers must be minute and by their detailed investigations must endeavour to assist the bacteriologists.*

The discovery of a bacillus as the supposed cause of Tetanus certainly took clinical observers by surprise. No one expected it. The disease is neither infective nor contagious, nor does it ever prevail epidemically. It is in temperate countries rare, and its cases occur, one here and one there, over the length and breadth of the land. It may end fatally

* I have myself already done what I could to elucidate this subject. My lectures on Lupus given before the Harveian Society will be found in the pages of the *British Medical Journal* for 1888. I purpose shortly, if engagements will permit, to reprint them with additions.

in a few hours or it may be protracted over months. The injuries from which it usually results are most various in their kinds, and most of them such as do not appear to carry with them any risk of contagion. Nothing in its clinical career looks like an infective malady due to a specific virus. Everything rather suggests a travelling neuritis originating in injury and tending to implicate the spinal centres. Yet we are told that it is certainly due to bacillary infection. The supposition is, I believe, that a certain specific bacillus, very widely prevalent and nowise hurtful unless introduced into a wound, every now and then gains access to one and evolves the phenomena of tetanus. We may, I suppose, if we like, still keep the theory of infecting neuritis as one part of the chain, but this neuritis is held to be set going by infective material and to be throughout associated with it. One little clinical fact certainly gives some support to this creed. I allude to the statement that the bacillus of tetanus is often found in earth, and to the fact that contused and earth-contaminated wounds seem to be especially prone to be followed by this fearful malady. After all, however, this goes for but very little, for very many tetanus-producing injuries are of a nature in which such contamination is impossible. Especially I might mention burns, which it might be supposed were the least likely of all injuries to facilitate the implantation of a local poison. Many years ago I endeavoured to confute by statistics the prevailing opinion that the male sex is, than the female, more prone to tetanus. My argument was that women were less liable to the injuries which evoked it, and I produced statistics proving that burns, the special form of accident to which women are more liable than men, produced a larger number of tetanus cases in females than in males.

I have already asked attention to the facts which seem to make it probable that catarrhal inflammations, taking their origin from exposure to cold or damp, and evoked through the reflex functions of the nervous system, may under certain circumstances become infectious and prevail as epidemics (see ARCHIVES i., 307). With the catarrhal affections, according to my present light, go the diphtheritic ones. I

cannot acknowledge any specific distinction between membranous croup and membranous diphtheria any more than I can between sporadic catarrhs and catarrhs which prevail as epidemics. In each case the results are obtained by breeding up a specific virus which in the beginning found its advent in an attack of inflammation which was not due to contagion. I purposely avoid saying that it originated in an inflammation, for the latter may have afforded only the occasion for its development and not have been in an absolute sense its cause.

It comes, perhaps, to this, that the tissue disturbance which we term inflammation always and even in its earliest stages, enfeebles the structures affected, and renders them an easy prey to parasitic germs which are always and almost everywhere present. We have then to keep before our minds two things—the antecedent tissue-damage, and the exposure to contagion. By successful attention to either, the development of a specific form of inflammation may be prevented. This was indeed the germ-theory of Lister, from which such splendid results have accrued. In a vague manner this theory had floated before the minds of our forefathers. The glory of our great cotemporary is that he gave it emphasis and precision, and above all that he applied it to practice. It is certainly true, and to find out its exact laws and limits is the task of the future.

CASE OF SIMULATED VACCINATION-SYPHILIS.

I HAVE had another case under observation of gangrene after vaccination with calf-lymph, and with certain symptoms simulating syphilis. The case is indeed the counterpart of Case I., ARCHIVES i., 110. I have preserved a portrait showing the condition of the arm and the location of some of the nodes on the skull. Over leaf I have given a tabular statement of the facts on the "space-for-time method," and I need not therefore trouble the reader with any other case-narrative. The facts in which the two cases resemble each other are that the infant was perfectly healthy up to the time of vaccination, that the lymph used was not taken from the human subject, that the skin around the vaccination-sores passed into gangrene with at the same time a large gland swelling in the armpit. To these must be added that periosteal swellings of considerable size formed on the skull bones, and that suspicious sores occurred on the skin. Further I may add that both patients appeared to be much benefited by the use of mercury, and that in particular the periosteal swellings rapidly subsided. It is obvious that these two cases give mutual support to the belief that no accidental contamination of the calf-lymph by syphilitic secretions occurred. This was a suggestion which, although there was not the slightest evidence in its support, it was difficult to wholly exclude in an isolated case. It is, however, improbable in the highest degree that such an accident should occur in two cases, and in each should be followed by precisely similar results. There remains then the question: Were these infants the subjects of a latent inherited taint which vaccination roused into activity? In neither case was there the slightest evidence that either parent had suffered from

syphilis, and in neither had the infant prior to vaccination shown any symptoms. In one case the child was a first-born, but in the other there was a healthy elder child. The final supposition is that it is possible for vaccination independently of any syphilis, whether implanted or hereditary, to evoke symptoms which have hitherto been regarded as peculiar to the latter malady, and which are apparently greatly benefited by specific treatment. On this point we must hold our minds open to the reception of further evidence. For the present I have only to add that two other cases which I recorded at the same time presented an almost identical chain of phenomena, with, however, the difference that they were both vaccinated from human lymph. I have also been made acquainted, though not in full detail, with several other more or less similar cases, and in none has there been any real proof of syphilis. One thing seems to me quite certain, that if these cases have anything whatever to do with syphilis it is with an inherited taint, and not with the introduction of the virus by vaccination. The phenomena, as well as the history, are wholly different from those of the latter class.

CASE IV.—DR. L——'s PATIENT (seen by myself in consultation).

A healthy first-born child, vaccinated at three months with calf-lymph. Slow development of vesicles. Inflammation of the arm in the third week. Gangrene of vaccinated area, with large mass of glands in armpit. Three nodes in skull. Pustule on nose. Recovery under specifics.

AGE.	DATE.	DETAILS.
	1890. July	Born of healthy parents, and apparently quite sound.
1 month	August	In fair health.
2 months	Sept.	In fair health.
3 months	Oct.	In fair health.
	„ 15	Vaccinated with Renner's calf-lymph at the same time as several others who did quite well. On the eighth day only one place seemed to have taken, but later on all three looked satisfactory.
4 months	Nov. 4	Arm inflamed: large black scabs with pus at their edges. 11th, Seen by Mr. Hutchinson. A large slough comprised all the vaccination sores, and passed deeply almost to the bone. Pustule on ala nasi, and three nodes on the skull. 22nd, Slough separating and nodes subsiding under specifics. Sketch taken.
5 months	Dec.	Doing well.

TREATMENT OF LUPUS BY KOCH'S FLUID.

I HAVE had as yet only two cases under my own care in which we have tried the treatment by injection of Koch's fluid, and in both the disease presented some peculiarities. In both the details of the treatment were undertaken by Dr. Heron, to whose kindness, care, and caution the patients, as well as myself, are very much indebted.

My first case was that of a little boy in whom the lupus was too extensive for any other method of cure. It was of the vulgaris form, but most unusually multiple and wide-spread in its manifestations. This patient was shown in connection with my Harveian lectures three years ago, and again more recently at the Dermatological Society. Two portraits showing his condition at different dates are in the collection of the College of Surgeons. The case was one, therefore, in which if a cure had resulted, the conditions could have been definitely contrasted with the previous state. Unfortunately, however, I cannot say that any great benefit has accrued. On account of the great extent of the disease, Dr. Heron commenced with very weak injections, but their strength was afterwards increased, and they were eight times repeated, with good reaction on all occasions excepting the last but two. The only effect on the lupus patches that we could observe has been that some of them have suppurated more freely, and that others have looked rather more red and shed scales more abundantly than they did before. Many of them, however, have not displayed any changes whatever. There is no reason for believing that the boy is either tuberculous or scrofulous in any other sense than that he is the subject of lupus.

My second case is that of a lady who has for two or

three years been the subject of lupus erythematosus. The patches and discs are numerous, and almost cover her face, scalp, and forehead. There are some also on the upper part of her chest. She is a lady of 55 years of age, in good health at present, but who in early life was considered to be consumptive. It is not improbable that she has the remains of tubercular disease in one lung, but she has no active symptoms, and has not recently lost flesh. Concerning her case I may report very briefly that the injections five times repeated, and on the later occasions in full strength, have produced full reactions, and once or twice made her feel very ill, but they have had no very obvious effect on the patches of lupus. The latter have sometimes looked redder than before, and we have tried to think that they shrivelled somewhat, but certainly there have been no definite changes. It will be seen that this case is an example of the erythematous form of lupus, one in which I believe as yet the presence of the bacillus has never been proved. We had, therefore, no right to expect that the Koch treatment would cure it. The trial was, however, well worth making, for as I many years ago attempted to prove, lupus erythematosus occurs much more constantly in association with a definitely tuberculous history than does lupus vulgaris. This fact is illustrated by the present case, as the lady has been suspected of phthisis. The reactions which occurred may have been in connection with some remains of tubercle in the lungs, and not in any reference to the lupus. This was, I believe, Dr. Heron's view.

Should it seem worth while in the future I shall recur to these cases, and record them in more detail.

Postscript.—Since the above was written, the patches of erythema on the cheeks in the second case have to a large extent disappeared. Those on the chest remain. The improvement occurred suddenly ten days after we had abandoned the injections under the belief that they were not affecting the disease. It is too early to venture any opinion as to whether the improvement will be permanent, or whether it is in any way connected with the treatment.

NOTES ON CANCER AND CANCEROUS PROCESSES.

(Continued from page 144.)

On Senile Moles and Senile Freckles, and on their relation to Cancerous Processes.

IN the case of Mr. K——, an elderly Scotchman, we had an excellent illustration of the development of papillary moles in senile periods of life. So far as he was aware, he had not had any moles in childhood, and their development, as about to be described, had commenced only about ten years before I saw him—that is about the age of 58. They began, he believed, on his back, but others appeared not much later on his face and right leg. The condition of his back when he consulted me is well shown in a portrait which was taken at the time, and is now in the possession of the College of Surgeons. Between his shoulders, and from the nape of his neck to his loins, were scattered a number of low papillary growths, most of them more or less pigmented. They were all abruptly circumscribed, and most of them smooth on the surface. None were in the least warty, although many showed a slight tendency to markings on the surface like those on a turkey's wattle. Some showed very little pigment indeed, whilst others were nearly black. The largest was not as big as a sixpence. Amongst them was one which a little differed from the rest in being more elevated, not in the least papillary, and in growing from its surface a single stout hair. This hair was probably of importance as proving congenital modification of structure.

On the right cheek, extending downwards in front of the ear and upwards on to the temple, was a large area, irregu-

larly margined, of a low and slightly pigmented papillary growth. The surface was level and quite sound, there being not the slightest tendency to inflammation or to warty developments. Its margin, which was quite abrupt, was like the rest of its surface, and not in the least like that of rodent ulcer. On his temple, a little in front of the patch just described, there was a scar, which he said had been left after destruction by caustic of a similar growth ten years ago. On his cheek on the same side there were four or five little pigmented freckles, which had recently appeared and were increasing in size. These showed no papillary hypertrophy whatever. Near to them and about the middle of his cheek was a little growth characteristic of rodent ulcer, with the usual rolled edge. On his right leg Mr. K—— had a coal-black patch about the size of a sixpence (see portrait), which was extending gradually at its edge, and which it was certainly quite impossible to distinguish from melanosis. A little lower than this was another, but slightly less marked, patch of similar character. It will be observed that all the principal patches which have been mentioned were on the right half of the body. There were, however, a few senile freckles on the left side of the face, and the moles on the back were in equal numbers on both sides of the spine.

Mr. K—— was quite confident that his moles and freckles were increasing in number and also in size. Their rate of increase was, however, very slow, and they gave him no trouble whatever. I destroyed the little patch of rodent on his cheek by a very liberal application of nitric acid, and used the same remedy for the papillary growth on the side of his temple.

In addition to the pigmented moles and freckles which have been described, Mr. K—— had a few florid nævi as large as number 6 shots scattered here and there; these were, like the others, supposed to be of recent development.

This case well illustrates what I have said as to occasional multiplicity of the pathological lesions which may occur in the senile skin. Whether any of them, and if so which, will pass on into processes which are positively cancerous, is as yet uncertain. That they are all dangerous I have no doubt.

The precise form of cancer will depend upon the precise tissue and region attacked. If the black mole on the leg, it will be melanotic sarcoma; if one of those on the face, it may be either the superficial or deep variety of epithelial cancer. All the places affected should be carefully watched, and upon the least indications of growth tendency being manifested, liberal cauterizations should be at once employed.

On Moles in their relation to Melanosis.

I have repeatedly seen pigmented growths much smaller than that which was present on Mr. K——'s leg originate glandular developments of melanotic sarcoma. I well remember a case in the London Hospital of which an elderly man was the subject, in whom a very large gland mass was present in the groin, and who was himself quite unaware of the presence of a small black mole on the foot which had originated it. A precisely similar, but yet more marked, example of this came under my notice some years ago in connexion with the examinations at the College of Surgeons. In this instance an old man between sixty and seventy had a glandular mass in Scarpa's triangle as big as a fist. It had been growing for a few months only, and feeling quite sure that it could not be primary, I made a diligent search on his foot, with the result of discovering a little black mole not so big as a split pea at the root of one of his toes. The presence of this mole had not previously been suspected. It had even been denied after an examination. No doubt it had become melanotic, but it is to be clearly stated that it showed no tendency to growth. It is a very remarkable fact with regard to moles which take on melanosis, and which may originate gland masses of very rapid growth and produce widely disseminated disease, that they themselves do not grow at all, and not infrequently they remain so small that their possessor never recognizes their existence.

It will be seen that in the above statements much depends upon our definition of the term "mole." It may be suggested that what I have so called were really not moles, but recent primary developments of melanotic sarcoma. It is quite true that the patients referred to were not themselves aware of the

existence of any congenital moles where the little black spots were found. Accepting, as I think we ought to, the broad definition of a mole as any local congenital defect of development of the skin attended by hypertrophy, we must next admit that many are so minute at the time of birth that they are wholly overlooked. Some, perhaps the majority, never grow, but many do at some period of their subject's life take on processes of independent growth. It is, as I have elsewhere suggested, probable that senility favours the growth of independent fragments of tissue of this kind, and that old people find out moles, often many of them, of whose existence they had not previously been aware. It is with these considerations in mind that I prefer to think the little black masses above referred to moles, rather than melanosis growing in previously healthy tissues.

On the peculiarities of the Skin in Old Age.

In describing the peculiarities of the skin in old age, we may notice first, a general and universal tendency to atrophic thinning, and to the wasting and loss of its appendages. Every one knows the appearances of the senile hand, the thin transparent skin which allows all the veins, tendons, &c., to be seen through. The subcutaneous fat has disappeared. The glands in the skin have shrivelled, the hairs have fallen out, and the whole thickness of the integument is little more than that of a piece of stout paper. These conditions, which perhaps reach their acme on the back of the hand, are to be observed in lesser degree on all parts of the surface, and are often very noticeable on the face. With this atrophy as regards thickness there is little or no tendency to shrink, and hence the formation of the wrinkles of age which in some cases and in some positions amount to large loose folds. As a direct consequence of this general atrophy, certain changes as regards function, and with them altered tendencies as regards disease, are to be noted. The senile atrophic skin does not perspire easily, and seldom becomes greasy from sebaceous secretion. It presents a dry, somewhat polished, clean and often crinkly surface. Old people show a much diminished liability to pustular eruptions, and to all diseases

which have their seat in the hair follicles or the adjacent sebaceous glands. If acne occurs it will be of the erythematous or rosaceous variety, with little tendency to pustules. Acne vulgaris and the formation of comedones are almost exclusively confined to young or middle-aged persons. The increased translucency of the skin in the aged, however, often makes old changes in sebaceous glands more visible than they had formerly been, and this is more noticeable on the face.

The atrophy of the glands generally, which is a part of the change which the senile skin undergoes, is of course well shown in certain special gland organs. The breast in women atrophies or becomes a mass of fat; the glandulæ Tysoni in the male prepuce disappears; and in women, again, Bartolini's glands atrophy to such an extent that they cannot be found. So also with the ceruminous glands of the ear. Simultaneously with this general arrest there also often goes a temporary depravation of function. Although the comedones so often seen in young persons as parts of the acne process are never observed in old persons, yet we do sometimes see peculiar forms of sebaceous disease. Accumulations of a very hard sebum may occur which distends the follicle into a cyst, but does not as in youth cause any surrounding inflammation.

The proclivities to disease in the senile skin are very marked, and perhaps few old persons can be found who do not display one or other form of them. Apart from the almost universal dilatation of blood-vessels in the face forming the "seaweed patches," we witness a sort of general emancipation from what may be called central control in the part of all structures. In the young when this escape from control occurs, the tendency is to inflammation, in the aged it is to modifications of growth. All these aberrations of growth tend more or less towards a malignant type. The simultaneous development of cancer of the skin in several different regions is by no means very uncommon in aged persons. Fortunately the cancerous process is usually very slow, and there is often a prolonged stage during which it is impossible to say whether the condition should be named chronic inflammation or one of malignant action. Any one

who will carefully inspect the skin of the face, neck, and bust of a few elderly persons, is almost certain to find illustrations of what I describe. He will find various modifications of the hypertrophied gland, of the freckle, of the papillary mole, and of the wart, and some to which it may be difficult to assign any name.

On Excision of Lymphatic Glands in cases of Cancer of the Tongue.

If the lymphatic glands have enlarged in cases of epithelial cancer of the tongue, it is as a rule very unhopeful practice to remove them. The operation ought, however, I am convinced, to be attempted in all suitable cases; and ought of course to be done in the freest possible manner. I am acquainted with three patients who are now living after secondary operations for the removal of lymphatic glands consequent upon epithelial cancer of the tongue. The best of these is a well-known gentleman in the city, a patient of Sir Joseph Lister's. Some months after the removal of the tongue for cancer, Sir Joseph excised a mass of glands which had enlarged in the floor of the mouth. I was not present at the operation, but believe that it was a most liberal one. The triumphant result has been that the patient is still living and well six or eight years later.

Two similar cases have occurred in my own practice, but in neither is the record quite so long.

In one, General M——, I had watched a case of extensive sclerosis of the tongue during many years. In spite of entire abstinence from smoking (which had been the original cause), a patch on the dorsum at length assumed suspicious characters, and I immediately performed excision. My microscopic friends, who examined the specimen afterwards, assured me that there was no proof of the disease being cancerous. I might thus fairly have hoped that I had operated in the pre-cancerous stage. Some months later, however, the patient returned with a single enlarged gland under his sterno-mastoid. It was isolated, and I advised its removal. This was done, and it was found to be crammed with cancerous elements. It is now four years since the

operation, and General M—— has had no sign of return of the disease in either the tongue or the glands.

In my second case I removed the tongue at a rather late stage of cancer, my patient being an artist and comparatively young. He was only thirty-eight, and the disease had progressed very rapidly. It was an acute and most dangerous form of cancer. At the time that I excised the tongue I removed also some glands under the jaw. Six months later, however, he returned to me with enlarged glands in the neck, between the angle of the jaw and the sterno-mastoid. With much misgiving as to the result I performed another free excision. I have just received from him a grateful Christmas greeting, with the assurance that he is still (three years after last operation) quite well.

ON MORPHŒA, DIFFUSE SCLERODERMIA, AND ALLIED DISEASES.

(Continued from page 40.)

No. VIII.—*Morphœa occurring in large patches on both sides of the body, and arranged almost symmetrically—Some peculiarities in the location of the patches which it was difficult to explain—Possible influence of irritation from the clothes—Note as to state five years later.*

ONE of the most interesting examples of the disease that I have ever seen occurred in the person of a gentleman named L——, aged 66, who was brought to me by Dr. George Hastings in October, 1884. The changes in his skin were located much as if they had been due to the irritation of a vest; that is, they occupied his trunk, upper arms, and thighs, extending but slightly to forearms and legs and entirely avoiding the face, neck, forearms, and feet. The scrotum, penis, and pubic region were also absolutely untouched. It was exceedingly difficult, not to say impossible, to explain the location of the disease by reference to nerve-distribution; yet it was not diffuse or universal, but in many parts occurred in abruptly margined patches. The most conspicuous patches were brawny, considerably thickened, and of a dull, yellow-white colour. The tint was more yellow than usual, and the lilac border was not conspicuous. The arrangement was most exactly symmetrical. I had no opportunity for dictating notes whilst the patient was undressed, and the following details, being from memory, may possibly not be quite

accurate. The diseased state commenced above on the root of the neck, the raised edge of the patch being very conspicuous on the sides and in front, but less so behind. The brawny hide-bound condition became somewhat less on the surface of the chest, and was not present over the epigastrium and mammary regions. A little below the epigastrium, however, there began a broad conspicuous belt which covered the whole of the abdomen downwards as far as the pubes, where it ended by an abrupt transverse line. This belt involved both sides of the abdomen and the back, and exactly corresponded with the area covered by a flannel belt which he was in the habit of wearing. The skin involved was distinctly thickened, hard and leather-like. It was quite impossible to pinch it up in the least. Passing down the groins on each side was a strongly-marked oblique strip of yellow-white induration. These strips joined the abdominal belt a little in front of the anterior-superior spine, leaving a triangular area, including the pubes, penis and scrotum, the skin of which was quite supple. Down the fronts and sides of the thighs long, broad patches extended, which tailed off a little below the knees. This tailing off of patches was noticed also on the forearms. On the inner side of each upper arm there was a very conspicuous white patch, nearly as big as the palm of the hand, placed not lengthwise on the limb, but transversely. It is not easy to assign the cause of this peculiar location. Both on the back, the arms, and the thighs, near to the patches which were well-characterized and yellowish-white in tint, there were many other smaller ones which were only of a dusky red.

The conditions just described had developed quite recently. The first patch had been noticed about three months before I saw the patient, on his left arm, and not long afterwards it appeared on the other also. The patches on the abdomen and thighs did not attract attention till a month later. It was believed that they had at first been more definitely oedematous and more swollen than they were when I saw them. No cause was assignable. Mr. L—— was an architect, of active habits and usually enjoying good health. He was, however, not feeling well at the time that the skin

disease commenced, but there was nothing definite. The state of his skin had caused him considerable annoyance from its hide-bound condition.

This patient was good enough in February, 1889 (five years after the above notes), to answer my inquiry as to his progress. He reported that he was in fairly good health for seventy years of age, and that his skin had somewhat improved in appearance. He had discarded all special treatment.

No. IX.—*Case of Morphœa in a boy, in whom the diseased tracts were arranged almost symmetrically—Proof of bilateral nerve-distribution—The lower extremities almost disabled.*

A very interesting example of this disease was sent to me by Mr. Cant, of Lincoln, together with a full account of the case. It was peculiar in that, at first sight, the affected parts appeared to be arranged with symmetry, although the disease was of the morphœa type and not diffused sclerodermia. On careful inspection, however, some deviations from symmetry were observed, and it became quite evident that there was nothing opposed to the hypothesis of nerve-distribution on each side. It was clearly an example of bi-lateral nerve-location. Thus, in the first place, a large patch on the front of the abdomen, just above the navel, was noticed, which extended equally on both sides. But on looking at it carefully, it was seen to consist of two patches which almost, but not quite, met in the middle line. These patches were white and lardaceous, and were of a long oval shape, curving downward and forward just like herpes zoster. There were some other smaller spots near to them on the sides of the trunk. It would be tedious to attempt to describe all the patches in detail. Both lower extremities were very severely affected (being much in the condition shown in the girl Ozer, of one of whose legs a cast has been preserved). In both the back of the thigh as far down as the popliteal space was quite exempt, whilst its front and outer sides showed long broad streaks of brawny induration. Below the knee, both in back and front, almost the whole of the skin was involved, the

brawny hardness being most conspicuous in front of the ankle. The right limb suffered more severely than the left. The skin of the right knee was so stiff and hard that he could not bend it much. The lowest part of both feet and all the digits had escaped with the exception of the middle toe of the left foot. This toe was drawn up, and its integument everywhere glossy and hard. The soles of the feet were on both sides exempt, and he could bend the ankle joints sufficiently with a little difficulty to stand on tiptoe. The skin of the whole of his back was quite healthy, as was also that of the lower part of the abdomen and of the whole of his chest, with the exception of ill-marked brownish patches symmetrically placed along the borders of the armpits. The upper extremities had also escaped with the exception of a long oval white patch on the back of the right forearm.

Some of the patches were not very conspicuous, especially those on the upper part of the trunk, and his mother had discovered that the best way of finding them was to feel for them, their rigidity being more easily detected by the finger than any peculiarities observed by the eye. On the legs the patches were of course very conspicuous indeed. Our patient was a healthy-looking boy, ten years old, in whom no cause for the malady could be assigned. His mother had noticed the patches on his abdomen first, but those on the legs were seen soon after. At first they were not easily seen, and she did not think them of any consequence. She did not consult any medical man until six months ago, a year after she had first observed them. She thought that the patches on the left lower extremity came later than those on the right, and that they had all increased considerably in size. It would not be safe, however, to place much reliance upon her observations in these respects, and it is probable that all the patches made their appearance nearly simultaneously, and had since been gradually passing through the usual stages, assuming by degrees features which made them more and more conspicuous. Of late the condition of his legs had rendered running and even walking somewhat difficult, and it was impossible for him to kneel. I was assured, however, that he had recently taken part in a game at cricket, but with

the admission that the exercise made the legs very irritable. Mr. Cant had for some time been treating him with arsenic and a weak iodine ointment, by which some improvement had been effected.

It will be seen that the parts exempt were the back, neck, head, and face, the digits excepting the middle toe of left foot, and the upper extremities excepting one patch on right forearm.

I saw Master M—— for a second time on July 29, 1887. He had then an inflamed ulceration on one knee. The limb was so much disabled that I advised amputation. Subsequently an ulcer formed on the ankle, and when I saw him for a third time in February, 1889, he was quite crippled by the disease, and as he suffered a good deal of pain from the ulcers I again urged removal of the limb. He was in excellent health, and was growing well in his trunk and upper extremities, but the lower ones were becoming dwarfed.

No. X.—*Morphœa in a young woman — Many patches in bilateral but not symmetrical arrangement.*

The patient whose case is the subject of the following narrative was sent to me by my friend, Dr. Port, in 1879. I copy the notes as taken at the time. Jane H——, aged 23. She had suffered from indigestion and palpitation for some years. About six months ago she began to suffer from neuralgia in left side of face. It lasted very severely for two months, and is still scarcely gone. Four months ago she began to experience a peculiar tingling in the right arm, and after a while she discovered that there were patches. About the same time her right leg swelled, and became much discoloured as if bruised. Subsequently she had similar tingling feelings in the cheeks and in the other arm, and other patches made their appearance. She thinks that there was an interval of two months between the first development on the right arm and the appearance of the patches on the cheeks. She has had a good deal of aching and smarting pain in the left leg and thigh.

She now has the following patches :—

Cheeks.—On each cheek the patch is in front of ear, beginning about on level of tragus, and extending downwards and forwards. The most marked ivory condition is near to the ear, but less distinct spots are to be found coming forward nearly to middle of cheek. On the right cheek it does not begin so near to the ear, and extends further forwards than on left. The larger patches are very dense and ivory like.

Right Arm.—It begins on the inner edge of triceps behind the upper arm a little above its middle, and passes downwards as a long irregular streak just in front of inner condyle, and along the border of ulna to wrist. Quite independently of this streak, her middle finger is swollen without any brawny condition, and the knuckle of the forefinger is rather painful. The right arm shows no changes, but she complains that the skin tingles sometimes, the tingling moving upwards in streaks.

On the left shoulder are two oval patches, dense and ivory-like, beginning close to spine, and extending outwards and downwards on the spine of the scapula.

On the right thigh there is a single small, rather indefinite patch, about the middle and exactly in front. Then over the head of fibula a large, broad, well-characterized brawny brown streak begins which covers the whole of the outer border of the leg and ankle, and extends to the root of little toe. This patch shows the changes in a more advanced state than any other, the subcutaneous cellular tissue being rigid, and the skin adherent to the deeper parts. This leg has given her so much trouble that she has been obliged to leave her place.

March 2, 1880.—I saw this patient again at this date, a year after the preceding notes were taken. The improvement was very remarkable. The position of all the patches could still in a good light be identified, the skin being white and polished. In some, however, it was quite difficult to find them, so little thickening or discoloration remained. The patch on the foot was the largest and most definite. Here the skin was thin and tight from atrophy. It could

not be pinched up, but the epidermis could be made to crinkle somewhat by pressure. There was little evidence at any of the patches of implication of the subcutaneous cellular tissue. The long streak along the inner side of the right forearm offered some exception to this, as here there was a condition of unevenness easily detected by the finger, and even by the eye, and caused apparently by atrophy of the cellular tissue.

The symmetrical patches on the sides of the cheeks could be discovered by the smoothness and hardness of the skin, but were not in the least conspicuous. The patient was florid and in good health. She was taken to the Pathological Society at its meeting on March 2, 1880, in order to demonstrate the fact of the disappearance of "Ivory patches." It is interesting to note that in this case the integument between the patches remained quite healthy, and that although she had patches on the cheeks, there was no reason to believe that her fifth nerves were affected. In each instance, the patch on the cheek occupied exactly that part of skin which is supplied by the facial branch of the great auricular from the cervical plexus.

No. XI.—*Single-patch Morphœa in a healthy man*
—*Partial disappearance.*

A man named James K—, aged 41, was sent to me by Mr. Herbert Miller, of Stoke Newington, on July 16, 1887. He had a single oval patch of morphœa on the right side of the trunk, just between the navel and the border of the ribs; it was very hard from tallow-like infiltration of skin, and was surrounded as usual by a narrow lilac rim. He had discovered it by accident in passing his hand over the part, which had not caused him the slightest inconvenience. (This patient attended at one of the college examinations for the Fellowship, and was seen by many of my colleagues.)

In February, 1889, Mr. Miller was kind enough to ask this patient to call on me a second time for inspection. Eighteen months had elapsed since I had seen him. The patch had, I found, to a large extent disappeared. It had thinned away,

and a slight depression, with some pigmentation around it, was almost all that remained. There had not been the slightest extension at the borders. It was now very evident that the thick homogeneous patch had been made up by the coalescence of many small spots. The latter had again come into view as absorption had progressed.

No. XII. — *Raynaud's symptoms in a married woman of middle age, followed by diffuse sclerodermia of both hands and face—Gangrene of one finger—Some improvement subsequently—Record of condition five years later.*

The patient to whom the following memoranda refer was sent to me by Dr. Hughlings Jackson in December, 1884. I am indebted to Dr. Clement Dukes, of Rugby, for the notes which enable me to record the state of things five years later. The case was one in which the phenomena of Raynaud's malady had preceded those of diffuse sclerodermia (or morphea). It will be seen that the face as well as the hands suffered. Mrs. S——, aged 41 (in December, 1884), had been married many years, and was the mother of five children. She gave me the following particulars as to her present illness.

Three years ago her hands used to "go purple." "If I lifted them up to comb my hair, all the blood used to go out of them, and they looked as if they were dead. Last winter they began to swell very much, and then they set. They did not set till last winter, and there was no pain till then. They began, however, to get a little stiff two years ago." She suffers very much from the cold.

Her legs and feet are a little cedematous, the skin pale but not hard. Her toes are apt to die; one of them is now as white as a candle.

The hard state of skin is limited to the exposed parts (the face and upper extremities). It shades off gradually from the face to neck, and is scarcely perceptible in the lower part of the latter. All her fingers are as stiff as wood. She was never strong; never had chilblains badly; always "nervous

and easily put about." Her youngest child is two years old. She used to take cod liver oil. She had small-pox ten years ago after one of her confinements.

The following are some particulars kindly supplied to me, subsequently, by Dr. Clement Dukes, of Rugby, under whose care the patient was. It will be seen that they record the gangrene of one finger, but some general improvement as regards the hide-bound condition.

"Mrs. S——, æt. 45. April 30, 1889. *Legs*: Swelled, patches of psoriasis on the knee only in front, and one place on the left knee behind. *Toes*: Swelled and blue as far as metatarsus. She keeps them from going quite dead by soaking them in *very hot* water every night. *Skin on face and neck* still a little hard, but not swelled. It has much improved. There are very marked *lines* all round mouth, radiating from the lips. *Right arm*: The wooden hardness formerly extended nearly to the elbow; now there is some hardness at the wrist, but none above. Comparatively the forearm is now quite soft. *Right hand*: The hand itself is now comparatively soft; there is some hardness remaining. *Thumb* less hard than any of the fingers. First finger very hard, flexed at right angle. Second finger very hard, flexed into palm, at angle 45°. Third finger very hard, flexed at right angle. Fourth finger: three years ago the hardness was so great that it obstructed the circulation to such an extent that the finger died and dropped off at the end of the first phalanx. *Left arm*: Much as right. Thumb softer than fingers. First finger comparatively mobile. Second, third, and fourth are flexed at right angle, and of comparatively little use. Soaks daily in very hot water, from which she finds great relief, and they do not die now. She has wonderfully improved in all respects, and in general health, and in the gradual disappearance of the hardness, since 1884. She takes continuously citrate of quinine and iron, and cod liver oil. If she omits these remedies she says she goes back directly. Change of air also improves her greatly."

No. XIII.—*A group of lardaceous Morphœa spots arranged like Zoster on one side of the abdomen.*

Dr. Barlow brought me a gentleman named P——, about 32 years of age, and, excepting dyspepsia, in good health. For the last two months he had had a belt of erythema with slight induration on the left side of his abdomen. In the middle of this belt a number of white lardaceous spots had slowly developed. The belt was in form and in curve exactly like herpes zoster. It covered the side and front of abdomen, ending just below the umbilicus. It passed the middle line a little, but not more than we often witness in zoster.

The lardaceous spots, as big as sixpences, very numerous and ill-defined, were most characteristic, and in the middle of the group there was slight brawny induration. Above and below the group the skin was congested, red, and very slightly swollen. The margins of the erythema were not very abrupt, but still easily noticed. Scarcely any irritation had attended the development of the disease.

No. XIV.—*Case in which after an interval of ten years a second patch of Morphœa was developed*
—*Details as to the condition left after resolution*
of the original patch.

The following note refers to almost the only case in which I have ever witnessed what may be called a second attack of morphœa. In the first instance a single well-marked ivory patch occurred on the scapular region of a young girl. In the course of years it thinned away. Ten years later, however, another smaller patch developed not far from the first, just as we sometimes see a second outbreak of herpes zoster.

Miss J—— comes to me to-day (Feb. 12, 1878). She is in fair health. The upper patch is an oval about an inch and a half long, and begins a little to right of the spine of seventh cervical. It is simply a little red over the whole surface; no lardaceous deposit can be detected. It looks much like a stain left by a blister. On touching it, however, a definite degree of induration is at once detected. This is greatest in the middle, and shades off gradually towards the edges. Between this patch and the older one is a belt of healthy skin about an inch and a half in width. The lower patch is three or four inches long by two and a half wide, and is oval. The skin is in the middle much thinned, and can be pinched up in a fold not a third the thickness of that of the opposite side. This loss of thickness is chiefly due to atrophy of the subcutaneous fat. The edge of the scapula beneath is much too easily felt. The middle of the patch shows broad white seams, smooth and glistening. These look much like the ivory patch, but consist of scars and are not thickened.

A broad belt round the patch is of dusky tint, from congestion then and there.

No. XV.—*Case of slightly marked Morphœa affecting one half of the face in a woman, with dilatation of the pupil and loss of accommodation.*

Through the kindness of Mr. Nettleship I had the opportunity of seeing an example of fifth-nerve morphœa in which the local changes were singularly slight. You could just notice in a good light that the left half of the forehead was slightly shrunken, and that on the left malar bone, left side of nose, and left half of upper lip, were white ivory-like ill-defined patches. These changes were definite when once seen, but might easily have been overlooked. The patient herself had, in fact, overlooked them. She was extremely lean, and the other side of her face was most unusually thin, and this no doubt helped to reduce the contrast, probably also it restricted the extent of change. By the finger it was scarcely possible to appreciate any hardness, and at no point was it impossible to pinch up the skin a little. It seemed probable from the woman's statement that the changes had been present nearly a year. She had consulted Mr. Nettleship on account of inability to see well with the eye of the affected side. Its pupil was dilated and motionless, and she had paralysis of accommodation. With a + 10" she could read well. The pupil measured about No. 12 in contrast with No. 4 in the other eye. She had been aware for nearly six months that her sight had been failing and the pupil enlarging. She had no deafness, and there was no paralysis of other orbital muscles. On the hypothesis that morphœa changes depend upon some disease of the vaso-motor inducing contraction of blood-vessels, the dilatation of the pupil might be considered to be readily explained, since spasm of arteries and dilated pupil are usually associated. It is not, however, so easy to account for the loss of accommodation, since that function depends chiefly on the third nerve. Indeed it is more probable, noting this combination, that the mydriasis is

paralytic than spasmodic—due, that is, to paralysis of the circular fibres supplied by the third nerve. The complication is an exceedingly important one, and may perhaps help to the solution of the enigma as to the true nature of morphœa.

No. XVI.—*Note on the exemption of Infants from Morphœa.*

Infants do not ever suffer from the lardaceous patch morphœa. It may be that in them the development of the nervous system is not sufficiently advanced to permit of the production of these phenomena, and that in them the causes which would in adults produce such results are attended by other changes. The period of liability to herpes and to morphœa as regards age is almost exactly the same. Both begin to occur about the age of five, and are tolerably frequent and often severe between that age and the period of puberty. Both diminish in frequency as age advances, but either of them may occur even in the old, and when they do so are usually attended by features of peculiarity.

(*To be concluded.*)

CASES ILLUSTRATING DISEASES OF THE NAILS.

THE tenth of my clinical lectures on "Certain Rare Diseases of the Skin," published in 1879, is devoted to affections of the *Nails*. During the twelve years which have since elapsed, many cases of much interest have come under my notice, and the subject has developed in various directions. I now purpose to record some of the more important of my recent facts. I shall reserve for my next number some general comments on the group, and an attempt at its classification in subdivisions in relation with special causes and combinations of causes.

No. I.—*Chancre under a finger-nail, followed, in the secondary stage, by inflammation of all the finger-nails.*

A very peculiar condition of general inflammation of the finger-nails was presented in the case of Mr. P——. This gentleman was under my treatment for primary and secondary syphilis, and had been taking small and, I suppose, inadequate doses of mercury for more than a month when his nails became affected. He still had the remains of an eruption. Suddenly all his finger-nails became softened over their lunulæ, and the nail beds, as seen through their substance, were of a dusky red. The whiteness of the lunulæ was quite lost. The nails were somewhat tender at the affected parts, but there was no pus-secretion, nor any material congestion of the adjacent part of the finger. His toe-nails were not affected. These statements apply to April 12, 1890, and it was then

sixteen weeks since the disease had been contracted. I had seen him for the first time on March 9th.

Now there was an important fact in Mr. P——'s history which might possibly have much to say to this peculiar development of onychitis. His original chancre had been, not on the genitals, but on a finger. He was a South American, and according to his own account he examined a prostitute in New York in order to know if he should be safe, and finding evidence of disease told her what she had and declined to go any further. But meanwhile, in spite of his disgusting precautions, he had been infected. Three weeks after the occurrence the nail of his right middle finger inflamed, and soon became very sore and painful indeed. Neither he nor his surgeon, however, suspected anything until an eruption appeared, although meanwhile there had been an enlarged gland above the elbow and another in the armpit. When the eruption showed itself the diagnosis was made and mercury was at once administered.

Mr. P—— consulted me on his arrival from New York. (March 9th). His finger was then healed, but the nail was much broken and deformed. The enlarged glands could still be found, and there were peeling patches in the palms and some blotches on the arms. It was then twelve weeks since the exposure. There had not been any sore throat. I prescribed mercury in somewhat larger doses than he had had it. He was a very self-willed man, and I doubt much whether he took it regularly. His palmar psoriasis disappeared, but some pustular eruptions on his head and face persisted up to the time (one month later) when he came to me with his nails inflamed. In addition to the symptoms mentioned, there were some little lymphatic knots in the subcutaneous cellular tissue of various parts.

During March and April Mr. P—— remained under my treatment. In the beginning of May he had acute orchitis in connection with a gonorrhœa. For this I prescribed tartar emetic.

May 26th.—He is taking the potassio-tartrate of antimony in eighth of grain doses three times a day, as well as his mercury (gr. ii.), and is not in the least sick.

Although the epididymis is still much swollen, and the vas as hard and as large as a quill, he has no tenderness or pain, and walks about in comfort. He suffers much giddiness in rising from bed, but he attributes this to his old ague, as he had it in the tropics formerly. His rash is gone. The nails are better. One of them has become loosened under its free edge, and appears likely to fall.

June 18th.—His nails are almost well, and he is better in all respects, but some fresh spots have appeared on the sides of the chest. They are livid. The epididymis is much thickened, the vas constituting a convoluted hard tube as thick as a pen-holder. It is not painful. He is now again leaving England.

Comments.—In connection with this case, which is a good example of syphilitic onychitis when general, I wish to ask attention to the mode in which the disease began. It was by congestion of the nail-root as demonstrated by dusky redness of the lunula. The destruction or exfoliation of the nail was secondary to damage caused by inflammation of its root. The same mode of commencement is observed in some affections of the nails which are not syphilitic.

Affections of the nails in the early secondary stage of acquired syphilis are not very common. It may be a question whether the circumstance that the chancre affected a nail had any influence in causing a preference for these structures. I have, however, seen many cases of chancre of the nail (midwifery chancres) which were not followed by general onychitis, and conversely I have seen several of general onychitis from syphilis, in which the original chancre had been on the more usual part. I am inclined, therefore, to regard the occurrence in this instance as merely a coincidence. It is one, however, worthy of being kept in mind.

No. II.—*Inflammation and Exfoliation of all the finger-nails in the secondary stage of Syphilis.*

Mr. D——, æt. forty-eight, a widower eleven years, came to me on Sept. 16, 1889, for a threatened attack of gout.

His history was that he had had syphilis two years before, for which he was six months under mercury. His earliest secondary symptom was, he told me, inflammation of the nails. All his nails fell off. They have since grown well, and when he came under my notice they were quite smooth and good. Subsequently to the nails becoming bad, he had a rash and inflamed tongue.

This case appears to have been a clear example of falling of the nails in the early stage of syphilis. It is to be noted that the detachment was, as in the preceding case, attended by inflammation. Thus the process does not appear to be precisely analogous to the falling of the hair which we often witness in syphilis, and which is unattended by any form of inflammation.

No. III. — *Shedding of the nails in Infantile Syphilis.*

In a portrait published in the Atlas of the New Sydenham Society, I have given several illustrations of disease of the nails in connection with inherited syphilis. They differ a good deal in character in different cases, and these varieties are usually in relation with the age at which they occur. When affected in early infancy the nails are not unfrequently shed.

I am at present attending the first-born child of a father who married too soon after his syphilis. It had in the first instance slight snuffles, then painful swellings on its arm-bones at various places, and a little later an eruption. Under treatment all these symptoms rapidly subsided, and the child, now five months old, is thriving. It appears likely, however, that it will lose all its finger-nails. They were from the beginning "pinched" and somewhat congested, and now a process of loosening, which begins from near the root, is in progress.*

* See also "Transactions of the Pathological Society," vol. xiii. p. 260. I have in that paper asked attention to the peculiar appearance of having been pinched laterally, which is often a most characteristic feature.

No. IV.—*Little black streaks in the substance of the finger-nails—Liability to them extending over ten years in a middle-aged man.*

The following notes describe a condition which I do not remember to have seen often. It would have been wholly unobserved had not the patient himself, an intelligent surgeon, noticed it.

Dr. E——, æt. 55, has been for ten years liable to the appearance of little black linear spots, or rather streaks, in the substance of his nails. They come at various parts but never over the lunula, usually in the anterior third. They are all alike quite black, but he thinks them of hæmorrhagic origin. They travel with the nail to its edge, and he then cuts them away.

He associates with them a certain tenderness and irritability of the finger-ends and hands which passes up the arms. It is transitory. He does not associate them with gout or indigestion. He is seldom without them. Sometimes three or four come at the same time. The thumbs are very seldom affected. The nails are otherwise healthy. He never gets the white spots which are so commonly seen.

No. V.—*Psoriasis affecting the nails of all the digits of both hands and feet.*

I have recorded at p. 456 of my little book on Syphilis a case of disease of the nails in which the diagnosis was doubtful. Although the patient had four years ago suffered from syphilis, I was inclined to regard the disease of his nails as common psoriasis. The conditions exactly resembled those of the non-specific form of chronic onychitis, and the patient had suffered from dry eczema before he had syphilis. Subsequently to the publication of the case further peculiarities were developed, which are described in the following notes :

Dr. Hawkins, of Bishopsgate Street, whose patient he was, kindly sent him to me again in November, 1887, about a year after my first notes. He had not had much treatment during the year, because it had been thought that the arsenic which I had prescribed caused dyspepsia.

His nails had got much worse, and now presented an extraordinary condition. They were quite loose from their beds in their whole length, from lunula to tip, but were neither fibrous nor broken. They continued hard and smooth on their surfaces, and gave him no inconvenience. Although they adhered at their roots only, yet they did not exfoliate, nor had they been often torn off. The root seemed to have extended upwards under the cuticle, and was at this part unusually strong, being felt under the skin as a very hard edge. The nail bed was quite dry. Most of the nails could be lifted up so as to examine the whole length of the exposed bed. In one instance in which the nail was curved we could look under it from side to side, as under the arch of a bridge. The roots of the nails were somewhat reddened and thick, but there was no pain. He had no eczema excepting a little on the scrotum.

There appeared some little reason to suspect that he was on the verge of locomotor ataxy. His "fits of dyspepsia" had been attacks of very violent and causeless vomiting much like crises. He said that his fingers easily became cold and numb. His knee-jump was poor. Pupils acted well. He had experienced some suspicious pains in the limbs, especially about the hips. He had been married two years, and had indulged very freely.

The nails of all his digits on both hands and feet were affected.

No. VI.—*Psoriasis of the nails — Nails loosened from their beds.*

The following observation, like the preceding one, concerns nails which cease to adhere to the nail-bed.

"The flesh is coming away from my nails" was the expression used by the patient. I found that the ends of his nails were undermined, and the nail thus detached from its bed. In some instances the condition extended half down the nail. In others it was only beginning. The nails themselves were not much altered, but were grey and opaque where loose.

It began on the right thumb three months ago. The

fingers on the right hand had not as yet suffered, but on the left hand the three ulnar fingers were all affected.

He was a man of 60, in good health, and had no psoriasis. He was a baker by trade, but had not worked of late.

No. VII.—*Changes in the nails in connection with Neuralgic pain in the hand.*

A case sent to me from the Queen's Square Hospital. Changes in nails. The condition of the two nails which are affected is very peculiar. The thumb has been removed. The nails of his middle and ring finger are in perfect nutrition and scarcely show transverse ridges. Those of the little and index fingers have shrivelled away, and become dry and fibrous. The whole finger tip has shrivelled and become pointed, and there is much corneous swelling about the root bed. The whole hand is much paler than the other, and though there is no special wasting of the muscles, the fingers and hand generally are thinner than the other. It is a condition approaching that of Raynaud's disease. The tips of the two fingers affected are slightly livid and congested, and look as if on the point of passing into dry gangrene. He complains that the hand gets cold. Everywhere the skin is hyper-sensitive, and the pulse on this side is much weaker than the other. It appears to be a case in which there is reflex disturbance of circulation, the pain probably causing arterial spasm.

No. VIII.—*Disease of the nails of the thumb and great toe on the same side—Senility a possible cause.*

A very curious and, to me, novel form of disease of the nails was presented in the case of Mrs. H——, an old lady of 70, in good health. The thumb of her right hand and the great toe of her right foot were the only digits affected. All her other nails were in good order. She had never had any form of skin disease. Nor could I find any explanation of the preference for the right limbs. She had never had

any form of paralysis, nor was she aware that the right side of her body in any way differed from the left.

The toe-nail had been the first to suffer. It had thickened, become opaque and loose, and a surgeon had removed it. It was, Mrs. H—— said, so loose that its removal did not hurt her. Soon afterwards the thumb-nail began to thicken also.

When Mrs. H—— came to me the thumb-nail was lifted up by epidermic growth under it, and it was itself opaque and thick. Its margins were concealed by dry epidermis, and around it there was a certain amount of swelling and congestion. The affection was distinctly one of chronic inflammation, though unattended by pain or tenderness. A sort of new nail had formed on the toe after removal of the first, but it was fibrous and soft, and was continuous with a dry epidermic crust which concealed its edges. As in the thumb, there was a certain amount of swelling and redness around it. I detached the whole nail and its adherent epidermis almost without hurting. The nail adhered only over a small surface. Its structure was so friable that it came away piecemeal. The nail-bed was left raw-looking, but not bleeding. The overhanging borders of the furrow were swollen but almost dry. After taking away the nail I brushed the whole surface over with Fowler's solution, pushing the brush well into the furrow. A sketch of the condition presented was taken as a memorandum, and I left the thumb to be dealt with next day.

The duration of the whole had been only about three months.

The following notes record the progress of the case under treatment:—

October 1st. Her nails are less inflamed. She has used the arsenic every other morning. It causes much pain. It is to be used only every four days and after careful cleaning away of all crusts and shreds.

October 15th. A peculiar feature in the case is the inflammatory swelling of the soft structures, especially around the root. A raised, dusky, red rim surrounds the root and sides of the affected nails. Under the use of liquor arsenicalis with morphia painted on every third day, both

the thumb and toe are much better. The swelling is less and there is scarcely any tenderness. She is taking nuxvomica and arsenic.

No. IX.—*Gout with fibrous Onychitis and destruction of all the nails—Senility a possible influence.*

A gentleman was sent to me by Dr. Myrtle, of Harrogate, who had suffered very severely from gout. His fingers were covered with chalk-stones, and there was a tophus in one ear. He was sixty-seven years of age, and his first attack of gout had occurred thirty-seven years ago. Both his legs were swollen and inflamed, and were in process of transition from solid oedema to elephantiasis. He assured me, and I could well believe it, that he had never submitted to any rules of diet. His only occupations had been, he said, shooting and fishing, and he added, "I should be at them still, if only my legs would let me." I have no doubt that he had lived very freely, but at the same time he had taken a great deal of exercise.

My reason for mentioning this case is, that the patient had by a sort of chronic and atrophic onychitis entirely lost his finger-nails. The nail-beds were bare and shiny, and showed only a few shreds and fragments which represented the nails. Remembering the condition which was present in Lady H—, and that she also had suffered from gout, I am inclined to suspect that there is a gouty form of disease of the nails. As a rule, however, I think that gouty patients have very good nails. They are usually hard, well-polished and bright. It is quite possible that in the case of the old gentleman just mentioned, calcareous disease of the arteries and defective supply of blood, combined with exposure of the hands in field sports, may have had an important share in producing the atrophy of the nails.

No. X.—*A modified form of Psoriasis of the nails with liability to numbness of hands.*

Mr. P—, a chemist, aged 39, came to me (June, 1889) on account of disease of his finger-nails. All his fingers,

excepting the two little ones and the middle one of his right hand, were affected, the thumbs and forefingers the most severely so. He said that his toes did not suffer. In all the condition was exactly alike, and consisted in the lifting up of the nail by the accumulation of epidermis between it and its bed. In all the changes began at the free edge. This accumulation was very hard and dry, and in some places spinous, as if from papillary growth. The free edge of the nail was in some places lifted a quarter of an inch from its bed. The nail where thus lifted had, of course, become opaque, but it was not roughened or fibrous in the least. As the conditions had developed rather rapidly (all as he believed within six months), it was clear that they were due to a constitutional cause. Yet Mr. P—— said that he had never in his life been in better health.

Three years ago, in consequence of dyspepsia and liver troubles, he had left Leicester and gone to a country village, where his health had been thoroughly re-established. He was almost a total abstainer, had never had syphilis, and knew of no history of disorders of the skin in his family. He had himself no trace of psoriasis or other skin disease. The only peculiarity which he mentioned as likely to bear upon the disordered nutrition of his nails was that he had recently noticed that his fingers were very liable to become numb. He called it failure of circulation; but it was clearly nervous, since it came from any kind of pressure. He often woke with one hand numb from lying upon the arm. His tongue was peculiar, being almost destitute of filiform papillæ, and consequently somewhat beefy (with sulci).

Arsenic had been given before I saw Mr. P——, and had, he said, made him so dyspeptic that he could not sleep. It had not been continued, and no other measures of treatment had been tried systematically. The nails were not sore, but if one happened to be caught in anything, great pain was caused. Mr. P—— was a married man with several children. He had recently been subjected to much permanent anxiety as to his prospects. One of his children had shown some dry eruption on the limbs, but nothing of much importance.

My diagnosis was that the condition was essentially psoriasis. The conditions differed a little from what I have often seen in psoriasis, in that the sides of the nails were not much involved, but only their free edges. The accumulation of subungual epidermis was also in excess.

No. XI.—*Chronic disease of nails cured by arsenic but followed by Lichen Planus—Symmetrical disease beginning at their roots, and attended by softening and thinning.*

A lady in splendid health had her finger-nails become fibrous and brittle. The thumbs suffered first, next the fore-fingers, and so on. She noticed the edge of the lunula to be too red in the affected nails; no heat of hands or finger-tips.* The breaking of the nails in buttoning things was her chief trouble. No skin disease whatever, but a daughter had intertrigo. Subsequent attack of lichen planus.

Mrs. W——, æt. 38, stout and healthy, consulted me first in July, 1889. Her ailment is a disease of all her nails. She has noticed that it begins by “redness of the half-moon” (the lunula). When this is red she feels sure that the nail will soften. The process is one of thinning and softening of the nail, not of formation under it or of hypertrophy. The nails are soft, red, and broken longitudinally. It begins in the root, and for a time the free edge is not affected. Her toe-nails are not affected.

She is in excellent health and stout. Never had any skin disease, excepting for some years a little roughness of face; nor does she know of any in the family. She has six children, and all have good skins excepting one, who is liable to intertrigo in elbows, knees, and neck. The nails began to be affected last September,* the right thumb first. It is now accurately symmetrical. The thumbs are worst, the index fingers next, the middle fingers are less affected, and the ring and little fingers escape. She had formerly beautiful nails, horny and hard. If the soft part of the nail is pressed, a very disagreeable

* It is to be noted that the nails got thin. There was no accumulation under them nor any loosening of their borders, only thinning and loss of lustre with fibrous fluting.

sensation is complained of, "not exactly pain." She easily catches the nails and tears them, but those most affected are so thin that there is nothing to catch. There is no general inflammation of the finger-end. There is rheumatic gout in the family, but no true gout.

Sept. 20, 1889.—The nails affected seem rather more smooth, but there are signs of the two middle fingers becoming attacked. The ring finger of her left had suffered before. The ring of right is free, and the little finger of both has escaped. She has always a cool hand—no discomfort excepting from the nails catching and breaking. She is taking the arsenic in seven-minim doses, with aperient. She thinks that it makes her "a little bilious," and causes the appetite to be defective. No other disagreement. She looks very well.

Nov. 12, 1889.—Her nails are almost well under full doses of arsenic (m v. and m v. of the two preparations *ter die*). We began on July 4th. She has had two attacks of irritability of skin "in every crease," behind knees, in neck, in elbows, and on waist. She left off the arsenic, feeling languid and tired. She became "brownish as if sunburnt," and has now been two weeks without arsenic. She has lost a stone since July, but is still stout. The arsenic caused throbbing in her heels and the skin peeled; she had much sense of weight in her feet.

She left off the arsenic for four days and felt better; took it again, and again had the same symptoms, and in an intensified degree. She had never had the pain in the heels before. It has quite disappeared since leaving off the medicine.

Jan. 30, 1890.—I last saw Mrs. W— on Nov. 12, and we left off arsenic as it disagreed. She took a little, however (one bottle), again in the present month. Her nails have continued to improve, and may be considered well, though still a little fibrous. She is in excellent health, but has now a new symptom in the development of groups of spots of lichen planus. It takes the form of polished flat-topped papules "in the creases." She had no skin disease whatever during the treatment for her nails. She never had any, excepting once some desquamative affection of the face, quite temporary, years ago.

She has felt very well indeed since the eruption appeared, and a severe contused wound which she received in her temple has healed remarkably well.

The eruption is very characteristic. It occurs on the neck, in the armpits, between and under the breasts, and on the trunk where the strings press. "If I scratch it the spots run together and become rough and scaly." This expression exactly fits the state of things. On her neck the papules are discrete, smooth-topped and shiny; on the waist these characters are quite lost, and the patches are scaly, rough and brownish. It is an intertrigo, in that it occurs in armpits, axillæ and popliteal spaces, and is just beginning in flexures of elbows. It occurs now on the thighs also. It itches at bedtime but not in the day. Nothing is to be seen in the mouth.

Mrs. W—— reminds me that in November she complained to me that her skin in some parts was dry and brown. We attributed it to the arsenic. The parts then affected were much those now attacked, but her face also was flushed. It was a temporary attack, and the face peeled after it.

She considers that she has always had "a dry skin"; one of her children also has a dry skin, and is liable to some eczema intertrigo.

May 14, 1890.—On Jan. 30 I ordered Antim. Pot. Tart. gr. $\frac{1}{16}$. She took it only three weeks. It abated the irritability seemingly very soon. She got influenza and left it off; she stopped the ointment also.

The antimony did not sicken (excepting once). The eruption is fading everywhere; as she says, "quite dead." The worst part on her waist is quite free from irritation. She is in good health; still constipated. The nails are for the time well, but she thinks "that at the root of the half-moons a little redness is showing, and this was the way they began before."

July 10, 1890.—Mrs. W—— informs me that it is just a year since she first came to me. She is now in excellent health. All her nails have long been well, but there is now a little tendency to relapse in the nail of right thumb, which is slightly rough and fibrous. She thinks that the lunula gets

red as the first stage. I do not observe much evidence of this.

The eruption which began, be it remembered, during the arsenic treatment for the nails, is now quite well, excepting some fading patches in waist. Mrs. W—— has been taking antimony in $\frac{1}{16}$ doses for two months, and says that she was never in better health. The patches in her waist are, she says, just where her dress presses.

Comments.—In the above case we have a good example of inflammation of the nails of constitutional origin beginning not as psoriasis usually does, but at the roots, and productive of thinning. It was, I think, definitely cured by pushing arsenic until distinct symptoms of disagreement occurred. The patient became brown, and the hands and feet numb. With the arsenic cure of the onychitis there came an eruption resembling lichen planus, and this in turn appeared to be cured by the use of antimony. One point of interest is that the nails were, after having been severely affected, restored to a state of perfect soundness. The patient lived at a great distance and came to London but seldom, a circumstance which must excuse the fragmentary character of the notes.

No. XII.—*Chronic inflammation of the ends of the digits in a healthy old man—History of frost-bite in early life.*

It is often of much importance as helping to the interpretation of exceptional phenomena to investigate the life history of the individual even at periods which may at first sight appear too remote to be likely to have taken any share in the result. By doing this systematically we often obtain unexpected light as regards the causation of the phenomena before us. The case which I have to relate is, I think, an excellent illustration of this, and proves that the whole of the patient's antecedents throughout his life should be taken into account if we would rightly explain the proclivities to disease exhibited by any of his tissues, limbs or organs, at later periods. It is by no means a case in which I would seek to

attribute what occurred in later life wholly to what had been suffered in former years. Few morbid processes are so simple in their nature that they can be adequately accounted for by one occurrence or one class of influences. Nearly all diseases result in their final sum from a partnership of causation in which several or many factors have taken their respective shares. To this statement the following case is probably by no means an exception.

A gentleman aged 72, the brother of a surgeon in Devonshire, consulted me on account of an eczematous inflammation of his hands and other parts, which had fallen with especial severity on his finger-ends and which had quite disorganized his nails. The condition of the latter is well shown in a portrait which is preserved in the collection of the Royal College of Surgeons. The disease was however by no means an affection of the nails only, nor had it probably begun in them. It was an affection of the ends of all his digits, displaying its most conspicuous features in the nails on account of their terminal position. The disease was said to have begun at the root of one finger-nail eight years before the patient consulted me. It had gradually spread, being always worse in cold weather, and better, though never quite well, in summer. When I saw him, all his nails, both of fingers and toes, were thinned and broken up, and at their roots the skin was in an eczematous condition, with in some cases deep cracks across their roots. During the winter of 1888 all his nails had, he said, come off. A few days of frosty weather were, he added, at any time sufficient to make his nails and finger-ends so sore that he was quite disabled. Recently the eczema had shown some tendency to spread to the body generally. The skin had become irritable, and was much scratched. The only parts which were really eczematous, however, were his ears. Mr. N——, although distinctly senile and reporting himself as “at times very weak,” looked tolerably well. He had, he said, never suffered from a chilblain in his life, and he had never had anything amiss with his fingers until eight years ago. He was an amateur gardener, and whenever not actually disabled was fond of using his hands in all weathers. On inquiring as to any

special cause for the conditions into which his hands and feet had passed, I found that forty years ago, when in Canada, he had once been severely frost-bitten. The parts affected by the frost-bites were his hands, feet, and ears, and these were precisely those on which the eczema had now appeared. The partnership which I would suggest in this case would be something like the following. The parts affected by frost-bite had probably suffered some slight permanent damage as regards their nutrition: so slight that during the middle periods of life, when in vigorous health, nothing occurred to them which was thought worthy of notice. When, however, the patient's vital powers began to fail in connection with senility, his arteries to become calcareous and his tissues generally to undergo retrogressive changes, then the effect of the old frost-bite became manifest. To this sum of influences we may add his recent habits of exposing his hands during gardening operations.

No. XIII.—*On overgrowth of the nails in connection with Venous Obstruction and Cyanosis.*

A case recorded by Dr. John W. Ogle,* and which I had the pleasure of seeing at the time, is of the utmost value, in proof that a retarded venous circulation favours overgrowth of the parts affected. The patient had an aneurism of his subclavian, which in the end occluded the artery, but which by pressure on the veins kept the hand in a state of cyanosis. The result was that the ends of the fingers became clubbed and the nails very much hypertrophied. They were broader, thicker, and longer. The fingers of the other hand remained quite normal. It is to be observed that in all conditions of cyanosis the fingers become clubbed, not overgrown as in acromegaly. It may be that overgrowth of the nails causes this expansion of the finger end.

No. XIV.—*Overgrowth of nails from neglect.*

I find gravely recorded in the Pathological Society's Transactions a case illustrating the length to which toe-

* See "Pathological Society's Transactions," vol. x. p. 104.

nails may grow when never cut and when exempted from the pressure of the shoe. Although the cause is obvious and one of the commonest, and the result scarcely deserves to be named "outgrowth of nails," yet I must admit that it was an extreme instance. The nails of the great toes measured respectively six and four inches in length, and the others in diminishing proportion until those of the little toe were scarcely larger than natural. The old lady, the subject of the case, was 84 years of age, and had died of natural decay in a work-house, no doubt bedridden.

Such overgrowth is very common in the claws of animals kept in confinement with no opportunity for wearing them down by scratching.

No. XV.—*Absence of the nails at birth, with Alopecia.*

I find mentioned in my notes of the cases of a brother and sister named Trigg, who had congenital alopecia, which persisted to some extent during childhood, that at the time of birth they had no nails. They were aged eight and seven respectively when under my observation in September, 1875. Their nails had then grown well, but the development of hair was still exceedingly defective. All the digits of both toes and fingers were affected.

ON HEREDITY IN REFERENCE TO DISEASE.

(Continued from page 53).

An instance of Congenital Distortion of the Hands in father and son—Association with Congenital Ptosis.

Whilst congenital distortions of the feet are tolerably common, it is extremely rare to witness anything of the same kind in the hands. I allude, of course, to congenital defects of the digits in which the muscles are implicated, and not to defects or superfluities. I do not at the present moment recollect to have ever seen an example of the former kind of deformity, excepting the one which I am about to mention. A gentleman who consulted me about another matter, presented a symmetrical and very peculiar deformity of his hands. The middle, ring, and little fingers were all turned towards the ulnar side, and at the same time somewhat bent towards the palm at the carpo-metacarpal joint. Thus the hand could not be laid flat on its back, and his remark was, "You would break the fingers if you tried to straighten them." His index finger could, on the contrary, be bent backwards. He could close his fist and use his hand well, but when he closed it, it was always with a twist towards the ulnar side. As he did not appear to much relish my paying attention to his hands, I did not examine them so carefully as I should have liked to have done. There was no paralysis, nor any defect in the formation of the fingers. The condition gave to his palms a peculiar appearance of hollowness. He told me that his only son had hands exactly like his own. The deformity of the hands in the father, and I believe in the son also (but I did not see the latter), was associated with congenital drooping of the eyelids. The latter condition was well marked in the

father, though not extreme in degree. He thought it had much diminished as he had got older.

*Family diseases as illustrative of inherited tissue proclivity—
Parallel between Retinitis Pigmentosa and Kaposi's Disease.*

In retinitis pigmentosa we have perhaps our best example of an inherited tissue tendency of which no evidences are ever present at birth, but the development of which is for practical purposes unconditional. No exciting causes seem to be required. I wish to speak cautiously on this point, for it may be that mere exposure to light is the exciting cause, failing which the retinal changes would not occur.

What retinitis pigmentosa is for the eye, Kaposi's disease or xeroderma pigmentosum is for the skin. In neither of these diseases are any changes in the vulnerable organ to be observed at birth, but in both they set in during very early life and are steadily aggressive. No exciting influences other than ordinary exposure to air and light are requisite to set them going, and no measures of treatment excepting exemption from exposure exercise any influence on their progress. In the one case the retina is disorganized with pigmentation, and in the other the skin (again with pigmentation). In the latter, the skin of exposed parts only suffers.

Both are "family diseases." If there be many brothers and sisters, two or more of them are certain to suffer. As regards Kaposi's disease we have probably a minor form in the tendency to freckle, but I am not aware that any minor form of parallel character has been observed in relation with retinitis pigmentosa.

Congenital defects of different kinds in the same patient.

An interesting case illustrating the multiplicity and at the same time the multiform character of congenital defects was sent to me from the Marylebone Infirmary by Dr. Savill. The patient, a young woman of 16, had a flabby hypertrophic condition of the skin and cellular tissue of both lower extremities, but more especially of the right. The skin could be taken up in loose thickened folds. In places there were

visible what looked like large varicose veins, but exceedingly ill-defined and without discoloration. The finger passed over some of these distinctly appreciated a hollow, but there was no definite filling of them with blood. These were especially present near to the knee and in the popliteal space. In some places what appeared to be a dilated vein presented itself, not as a tortuous trunk but simply as a globose elevation. There were two of these placed almost symmetrically on the inner edge of the buttock. They were quite soft as if containing fluid, and had a slightly bluish tint, but I much doubt if there was any circulation through them. The whole of the right lower limb was considerably larger than the other, but the left was involved to a slighter degree in similar changes. There were a number of the ordinary brown pigment moles on the skin of the back, one at least of considerable size, and all quite superficial. Interspersed with these were a few venous nævi of a deep purple colour, quite superficial, easily emptied by pressure and filling again immediately. The largest of these was on her right shoulder.

The case illustrates with emphasis what I have often observed before, that when there is a tendency to defect in development of the skin, it is seldom restricted to one tissue. Those who have nævi often have moles as well, and it may be several varieties of them.

Slowly progressive mutilation of both feet (Necrosis Mutilans)

—History of several members of the family very similarly affected (two generations)—Some tendency to affection of the hands also.

The following fragmentary notes refer to a very unusual case in which a woman has lost the anterior halves of both feet by a slow and painless necrotic process, not unlike that which occurs in the affections to which the adjective *mutilans* is applied. We have a *lepra mutilans*, a form of true leprosy (tolerably common), and a *lupus mutilans* (very rare). In the present instance there is no leprosy nor any proof of tendency to lupus; and a very remarkable feature in the case is that several relatives are said to have suffered from it. Concerning this latter point I am obliged to trust to the

woman's statements, for I have not myself seen those who are stated to be so affected.

The woman was under my care in the London Hospital many years ago, when I believe I published in one of the journals some brief mention of her case. Two years ago, whilst under the care of Mr. Clinton Dent in St. George's Hospital, she was brought by that gentleman to a meeting of the Dermatological Society, where I again saw her, and where her case excited great interest. I have never seen a similar case with a corresponding history, and desire now to place the principal facts on permanent record.

Mrs. E——, aged 58, single, rather stout and pale. Has kept at her work as a cook most of her life. Her disease began when she was 26, as "a corn under the tread of the great toe, which ulcerated down to the bone." The left foot was first affected, and soon afterwards the other. The process gradually spread from one toe to the others, and little bits of bone crumbled away. She had a good deal of pain in the feet before the abscesses broke and afterwards. At times she had swollen glands in the groins.

The disease has gradually progressed until it has destroyed the fronts of the feet and reduced them to their present condition. They have now the appearance of stumps after amputation through the middle of the metatarsus, but with the difference that small portions of the ends of the toes still remain. Thus most of her toe-nails are still present. She does not remember that she ever suffered from chilblains much, and she does not consider that she suffers from cold more than others.

There has never been any loss of bone from the hands, but they have not wholly escaped. There is some general thickening of the skin of the palms and palmar aspects of the fingers. Between the ring and middle fingers of both hands, in exact symmetry, a sort of ulcerated corn has developed which has resulted in closing up the web to some extent. Both little fingers are contracted, and the palms generally are tight.

Her parent's family was five brothers and herself. Two brothers have suffered in exactly the same way as she has

done. She believes that it began in one brother at ten years of age and the other at twenty. One of the brothers who suffers still works at Pickford's (younger than herself).

She believes that her maternal grandmother had her feet affected somewhat like hers. A cousin, a mother's sister's son, "had feet just like mine." He was "a fine-built man." Others have suffered more lightly. One had very "bad scurvy in the hands and feet."

Although I have repeatedly tried to get opportunities for examining her relatives I have not succeeded. From her statements we must believe that some tendency to similar conditions has been shown in several generations, though we may doubt her testimony as to there having been close similarity in all the cases.

The facts seem to point to the family prevalence and hereditary transmission of defective nutritional endowments of the extremities, especially of the feet. As the result of this the feet do not bear ordinary use. Somewhat analogous phenomena are witnessed, though with implication of different tissues, in examples of remarkable proclivity to corns. In rarer cases conditions of keratosis of the whole sole may result. Of this the case narrated at p. 74 is a good example. A still more remarkable one is found in a monograph published a century ago by Sœmmering, in which the palms and soles of a healthy man underwent peculiar hypertrophic processes, the disease extending through his whole life.

Perhaps, however, the closest parallels are found in the more severe examples of perforating ulcer of the foot. In this occasionally the bones become involved, and undergo necrosis in fragments. A condition of shortening of the foot may occasionally result very like that described above.

I have at present under observation a case of advanced ataxy in which this has occurred in one foot. I have seen the patient, on and off, for ten or twelve years, he having first consulted me for a perforating ulcer of the foot. Fragments of the metatarsal bones have from time to time come away without pain, and his foot has gradually become shortened, until it much resembles that of the woman whose case is described above.

Susceptibility to Contagious Disease.

Interesting facts may be collected in reference to hereditary susceptibility to special forms of disease, resulting either from contagion or other external influence, and incapable of spontaneous origin. It is admitted on all hands that the exanthemata, during the same epidemic, are apt to affect some families with far greater severity than others; and that sometimes in the same family several individuals may suffer very severely and several others very lightly, the difference probably being due to inherited peculiarity of constitution. There appears good reason to believe that in communities where certain specific poisons have been prevalent for many generations, a degree of immunity as regards their effects is obtained. Many facts are on record in proof of the severity with which the exanthemata affect races who have never before suffered from them, amongst the most recent of which we have the death of a whole company of Esquimaux in Paris from small-pox. Diphtheria, a contagious disease, although not a specific fever, is remarkable for the different degrees of severity with which it affects different individuals. Dr. Hubert Airey has recorded some remarkable examples of this. In two families attended by him, and each consisting of six children, every child suffered. In one family all recovered, and in the other five died. In another family, six out of seven children perished.

I have myself had occasion to do tracheotomy for the child of parents who, in three different houses, and at distant parts, had lost a child from diphtheria.

The Empress Josephine was, as we are informed by Brettonneau, liable to diphtheria. Her daughter Hortense suffered also. A son and nephew of the latter both died of croup.

There can be no doubt that in explanation of the different degrees of severity of contagious diseases in different persons, very large allowance must be made for inherited peculiarities of constitution; and that in many instances adjectives which have been used in connection with the name of the disease, or even the name itself, have been suggested by peculiarities

which were due, not to any modifications in the morbid cause, but to peculiarities in the patient.

Dr. James Reid, in the twenty-seventh volume of the "Medico-Chirurgical Transactions," has described the cases of two brothers who, of different callings and living in different places, were alike the subjects of tubular expectoration from the bronchi.

The late Mr. John Gay supplied me with the following fact:—

"Case of twins (females). They very closely resembled each other, and at the age of five both were simultaneously overtaken by whooping cough—no other case in the family—and both after a few days died, the only deaths that have occurred in the family."

Idiosyncrasy to Tobacco Amaurosis.

Some curious instances of the inheritance of an idiosyncrasy which ultimately leads to disease have come under my observation in connection with a form of amaurosis believed to be due to tobacco. Some years ago, at Moorfields, a young sailor who had been smoking largely presented himself with this condition. He told me that a cousin of his had been under the care of my colleague, Mr. Hulke, with failure of sight much like his own. On application to Mr. Hulke he kindly forwarded me the notes of his patient, in whose case he also had diagnosed Tobacco Amaurosis. In both patients the disease was arrested on disuse of tobacco. Some years later a woman who was the mother of one of these patients, and the aunt of the other, came under my care, being herself the subject of a precisely similar kind of amaurosis, that is, primary, symmetrical, pallor of discs without any other symptoms of nerve disorder. In her case I believe the disease progressed to absolute blindness. She had never smoked. In her the amaurosis came on at the climacteric period, whilst in the two young men it occurred in early life.

My impression is that we ought to regard these cases as showing the influence of tobacco as an exciting cause of a disease to which family peculiarity had already predisposed.

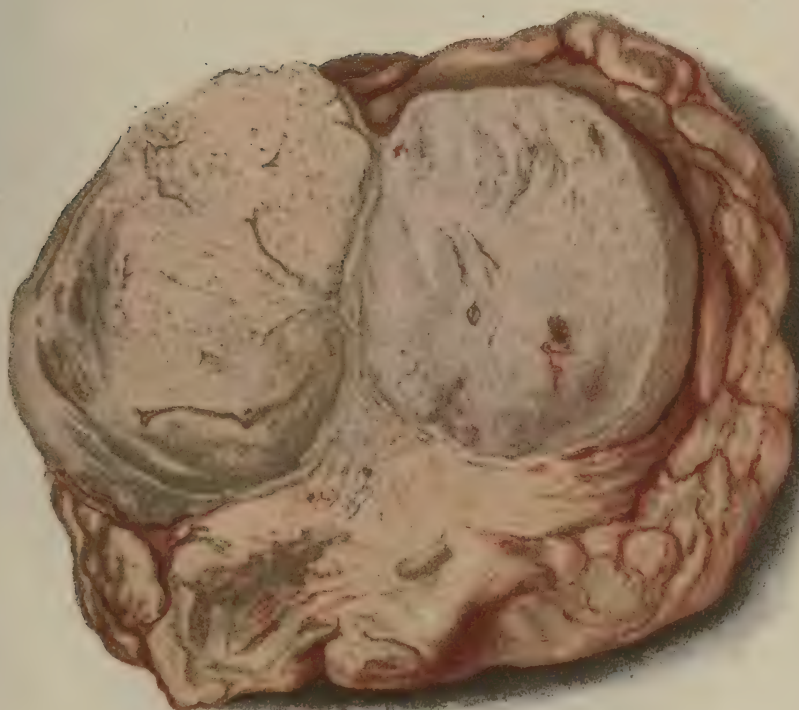
More recently a young clergyman from Wales has been

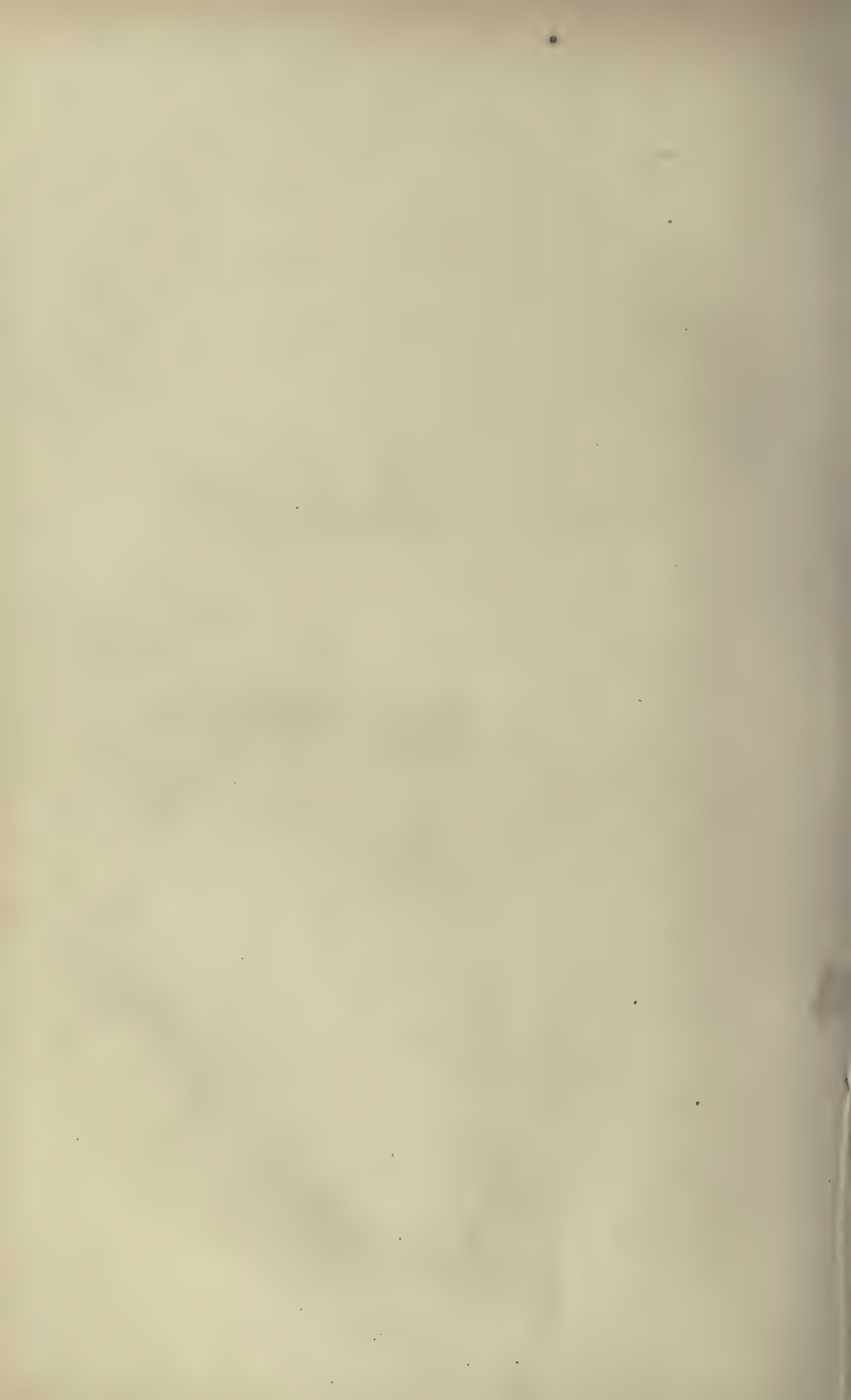
PLATE XXIV.

ADENOID TUMOURS IN THE BREAST IN THREE GENERATIONS, WITH SCIRRHUS IN ONE OF THEM.

THIS plate is of interest as an illustration of inheritance, and also of the supervention of malignant disease in close proximity with an innocent growth. The lower portrait shows the breast of a lady named Mrs. H—, and the upper one is that of one of her daughters. Twenty years ago I removed Mrs. H—'s breast on account of a rather rapidly-growing tumour. It proved to be a soft adenoid; no recurrence or gland implication ever took place, and she is still living and well. She was about fifty years of age at the time. A few years ago one of her daughters, Mrs. W—, aged forty, came under my care for a growth which I could not doubt was scirrhus. She asserted that she had had a tumour ever since girlhood. The section of the breast is shown in the sketch. It will be seen that there is an encapsuled and lobulated adenoid growth the size of a marble, and that around this there is a pale fibrous looking, ill-defined area of thickened tissue. The latter was characteristically scirrhus. It adhered to the adenoid growth, but did not infiltrate it. I have since removed the axillary glands on account of their implication. One of Mrs. W—'s daughters, a granddaughter of the first patient, has, at the present time, an adenoid tumour in one breast.

(SMALLER ATLAS.)





under my care with threatened amaurosis of the same kind. He had the characteristic central scotoma, on which he could not distinguish red and green spots. He had been living a solitary life, and smoking freely a coarse, strong tobacco. The chief interest of his case lies in the fact that he told me that two of his brothers were then suffering in a precisely similar way. They were both married men, farmers on the Welsh hills, under conditions very favourable to health. They were both liberal smokers.

Here again we seem to have examples of a family susceptibility to the poisonous influence of tobacco. It is to be added that there was no history of amaurosis in former generations, and that the parents were not consanguineous. Mr. Crichtett, who had seen this patient before I did, had also diagnosed Tobacco Amaurosis, and this was further confirmed by Mr. Nettleship, who carefully investigated the case at my request. There were four other brothers in the family, none of whom had suffered.

(To be continued.)

THERAPEUTICS, DIET, ETC.

(Continued from p. 91.)

No. VIII.—*A Plea for the more liberal use of Butter.*

No dietetic reform would, I believe, be more conducive to improved health amongst children, and especially to the prevention of tuberculosis, than an increase in the consumption of butter. Our children are trained to take butter with great restraint, and are told that it is greedy and extravagant to eat much of it. It is regarded as a luxury, and as giving a relish to bread, rather than as in itself a most important article of food. Even in private families of the wealthier classes these rules prevail at table, and at schools and public boarding establishments they receive strong reinforcement from economical motives. Minute allowances of butter are served out to those who would gladly consume five times the quantity. Where the house-income makes this a matter of necessity, there is little more to be said than that it is often a costly economy. Enfeebled health may easily entail a far heavier expense than a more liberal breakfast table would have done. Cod liver oil costs more than butter, and it is besides often not resorted to till too late. Instead of restricting a child's consumption of butter I would encourage it. Let the limit be the power of digestion and the tendency to biliousness. Most children may be allowed to follow their own inclinations, and will not take more than is good for them. The butter should be of the best and taken cold. Bread, dry toast, biscuits, potatoes, and rice are good vehicles. Children well supplied with butter feel the cold less than others, and

resist its influence better. They do not "catch cold" so easily. In speaking of children I by no means intend to exclude other ages, especially young adults. Grown-up persons, however, take other animal fats more freely than most children do, and are besides allowed much freer selection as to both quality and quantity. It is not so necessary to raise any clamour for reform on their account.

It may not be out of place to remark that if a greatly increased demand for fresh butter should result from a change of custom such as that suggested, it could easily be met by those concerned. There need be no increase in the cost of the article, whilst at the same time a benefit would be conferred on our home farmers.

No. IX.—*On the use of Aconite.*

I have for many years been in the habit of prescribing aconite in doses which my medical friends assure me are very dangerous. Yet I have never had any accident or an approach to one. My favourite preparation is the tincture (not Fleming's), and the dose ten minims three times a day. For rheumatic iritis I invariably order this, in combination usually with iodide of potassium and alkalies. On one occasion I had a remarkable illustration of its value. I had treated the same patient repeatedly for annually recurring and severe attacks of iritis. On one occasion he insisted that the medicine did not relieve him as it had formerly done. I compared my prescription with those of former years, and found that though very similar in other respects, I had omitted the aconite. It was added, and relief soon followed. Since that I have never forgotten it. In almost all cases of rheumatic affections attended by pain, aconite seems to suit, and I have used it also much in inflammatory states of the skin, eczema, &c., especially when they are pruriginous. For the pain of cancer it is also, I think, decidedly useful. I recently saw a lady who had for this object continued my prescription of ten minims three times a day for a whole year. It had never disagreed in the least, and she believed that it had to some extent controlled her pain.

From statements made to me by many professional friends, I am inclined to believe that there is far more danger in smaller doses at short intervals than in those which I use. I may repeat that I have never witnessed ill effects. My patients are always forewarned that they are using a powerful remedy, must be careful to measure the dose, and must leave it off if the tongue tingles. For acute inflammations of important viscera I have seldom used aconite, preferring the remedy next to be mentioned. I can well understand that if it be given every half-hour or every ten minutes, as some recommend, that however small the dose it will need most careful watching, and may easily prove dangerous. I can also easily believe that such administration may be very efficacious, for it is undoubtedly a very powerful remedy.* My chief reason for penning this note is, however, to bear testimony to the harmlessness of ten-minim doses not oftener than three times a day, but continued indefinitely, and to their efficiency in a variety of inflammatory, pruriginous and painful affections.

No. X.—*On Tartar Emetic in small doses, long continued.*

Tartar emetic is another of the remedies in which I place unbounded confidence for certain definite objects. In small doses long continued, I believe that without causing nausea or loss of appetite it is decidedly favourable to the subsidence of all local congestions. It tends to equalize the circulation. Many of my eczema patients have taken it in eighth of grain doses three times a day for weeks together, and have declared that they felt stronger and had better appetites than before. A sixteenth of a grain is, however, for this purpose usually sufficient, but it should be given not three times a day but every four hours (sleeping time excepted). I may admit that in giving small doses of any drug in this way

* Pereira records a case of poisoning by medicinal use in rheumatic fever. The patient's condition was for a time most critical, but he recovered and was completely cured of his rheumatism (page 2174).

without allowing it to produce any appreciable effect, it is never safe to infer that it does anything at all. Thus in eczema cases I always use local remedies at the same time. I state here my impressions. Concerning the great value of tartar emetic when pushed to nausea in acute inflammations, I recorded my experience some years ago in the Cavendish Lecture of the West London Medical Society.

MISCELLANEOUS MEMORANDA.

(Continued from p. 96.)

No. XI.—*On the importance of the systematic record of family histories in private practice, and of obtaining post-mortems.*

A clergyman on entering upon a "cure of souls" in a new parish ought to systematically acquaint himself with the history and peculiarities of his parishioners. He should seek to know what have been the virtues and what the failings of each family, and, when practicable, of its individual members. He should gradually acquire and register for future use as much information as he can of former generations. By so doing he would greatly enlarge his knowledge of human nature and fit himself for more definite usefulness.* Nor is it easy to imagine any more interesting pursuit for the scientific practitioner of medicine than the careful registering, in reference to inherited tendencies, of the peculiarities of individual members of the various families under his charge. In many instances he will be personally acquainted with all the principal facts respecting the health of all the members of the existing generation, and his knowledge will often extend to the preceding ones. From year to year, as time goes on, especially in village practice, when his patients are his neighbours, he will have the opportunity of watching the development of proclivities

* For examples of what I mean, the reader may consult the grimly accurate biographical sketches given in Crabbe's "Borough," or, if he prefers poetry, those which occur in Wordsworth's "Excursion," more particularly the pastor's narrative in "The Churchyard among the Mountains" (Book VI.). These last are as faithful as Crabbe's, and are also full of pathos and beauty.

already recognized, and of noting the influence of new combinations.

Portal has some excellent observations on this subject, and insists also upon the importance of performing autopsies in private practice "in order that those concerned should obtain for the benefit of the living, an accurate knowledge of family proclivities." We often hear it said that it is impossible to obtain post-mortems in private. I believe it to be much less so than is generally alleged. If the reasons for desiring to do them be rightly urged they will seldom be refused. With many the public good suffices, and very few indeed resist the plea that it will benefit the family.*

No. XII.—*On Circumcision as preventive of Masturbation.*

The appended letter has been sent to me from "the Refractory Gallery" of a lunatic asylum. The patient who sends it is himself a surgeon. I venture to bring it before my readers because I believe that the subject to which it refers is an important one, and that my correspondent's views on it are worthy of consideration. The subject is not a novel one. My late colleague, Mr. Curling, I know held the opinion that circumcision was of advantage as preventing the tendency to masturbation. At one time he tried to collect facts in order to institute a comparison between Jews and others in respect to that habit, but the distasteful nature of the inquiry I believe caused him to abandon it. It is indeed one upon which it is impossible to collect statistics. General impressions are all that can be had. I have myself, from considerable experience, formed a strong opinion that Jewish young men do not suffer nearly so frequently as others from the maladies which we associate more or less definitely with masturbation and nocturnal emissions. We must remember, how-

* Rarely indeed, according to my experience, will it be necessary to approach the *ultima ratio* of Hunter who, provoked by the insuperable and stupid selfishness which was displayed, at last lost his temper and exclaimed, "Then, Sir, I heartily hope that yourself and all your family, nay all your friends, may die of the same disease, and that no one may be able to afford any assistance."

ever, that in their case we are dealing with the circumcision of infants as preventive, not with that of adults as curative. Under the latter conditions the operation is far less hopeful. Still, I am inclined to believe that it may often accomplish much, both in breaking the habit as an immediate result, and in diminishing the temptation to it subsequently. I know that the reply from specialists will be that the disorder is in the nervous system, and not in the organs, and this no doubt is in part true. The reiterated complaints and confessions of hundreds of young men, however, force on me the conviction that the habit in question is very injurious to the nerve-tone, and that it frequently originates and keeps up maladies which but for it might have been avoided or cured. I confess I see no reason why a man admitted into an asylum for ailments associated with that vice should not be allowed such chance of relief as the operation offers. I may indeed go further than this and avow my conviction that measures more radical than circumcision would, if public opinion permitted their adoption, be a true kindness to many patients of both sexes.

THE HOSPITAL FOR THE INSANE, W——, E——,

Oct. 31, 1890.

DEAR SIR,—The *British Medical Journal* of the 27th of September, 1890, on p. 769, under the heading "A Plea for Circumcision," gives this quotation:—

"It is surely not needful to seek any recondite motive for the origin of the practice of circumcision. No one who has seen the superior cleanliness of a Hebrew penis can have avoided a very strong impression in favour of removal of the foreskin. It constitutes a harbour for filth, and is a constant source of irritation. It conduces to masturbation, and adds to the difficulties of sexual continence. It increases the risk of syphilis in early life, and of cancer in the aged. I have never seen cancer of the penis in a Jew, and chancres are rare.—JONATHAN HUTCHINSON, *Archives of Surgery*."

I have been an inmate here, Sir, for more than seven years, and shall feel exceedingly obliged if you will kindly tell me whether you are aware of any reason why, if I am a confirmed masturbator, circumcision should not be performed upon me?

Will you kindly also tell me whether you think that any good reason can be advanced why Messrs. L——, S——, H——, H——, and D—— (the first three quite young men), who have all told me that they masturbate, should not have circumcision performed upon them?

I mention these gentlemen's names because it seems necessary to establish the facts I mention, so that in the event of inquiry into the truth of my statement being made, you will find that the above gentlemen have been locked up here for many months past, that they have been masturbators during nearly,

if not quite, all that time, and that nothing worth calling efficient medical or surgical treatment has been given them, or been done to them, by either of the medical men, for the cure of this imperious habit."

I trust it will not be supposed from what I have written above that I believe that the removal of the testes or ovaries will either completely or in all cases subdue the sexual passion. All that I contend for is that such operations are often and in most persons conducive to that end.

A recent number of the *Gynecological Journal* has a curious misprint which expresses the truth more fully than the word intended by the writer. Discussing the question of suppressing sexual desire by removal of the testes, it is stated that in order to get that result "the whole pelvis must be taken also." The word which has been printed pelvis was no doubt "penis" in the manuscript, but the printer's devil has for once shown his physiological insight.

No. XIII.—*On the differences between Syphilitic Teeth and those damaged by Mercury in infancy.*

No two cases could better illustrate the differences between syphilitic and mercurial teeth, than those of two young ladies who were with me on the same morning a few weeks ago. One was the subject of zonular cataract, and the other of interstitial keratitis. In the latter there was the history, as usual, of very severe and long continued convulsions in infancy, and of the liberal use of mercurial powders for their control. All her incisor teeth were defective in enamel, and were thin, serrated, and discoloured. The eight premolars were all good, and well covered with white enamel; but the four test teeth, the first molars, were in every instance wholly denuded of enamel, and presented a rough spinous surface, which was much discoloured. In the patient who suffered from interstitial keratitis and was the subject of inherited syphilis, all the teeth were perfect and covered with white enamel, and of good colour, with the exception of the upper central incisors, each of which presented a single crescentic notch. In this instance the young lady presented no indications of inherited syphilis excepting her teeth and her

keratitis. She had not been ill during infancy in any way, and had consequently escaped mercurial treatment. In a large majority of instances in which we meet with syphilitic teeth, the patients have taken mercury in infancy, and the enamel-defects consequent upon its use are present together with the notch indicating hereditary taint. This frequent, indeed ordinary, coincidence of the two sets of conditions in the same case, has led to much confusion, and some difficulty of diagnosis on the part of those who have not learned to discriminate.

No. XIV.—*Cases illustrating the sequence of Alopecia areata after Ringworm.*

I have had during the present week two cases of much interest in reference to the hypothesis that common ringworm is the cause of alopecia areata. In the first of them a lady, the wife of a surgeon, came to me with large patches of alopecia on her scalp. She emphatically disclaimed at first all possibility of ringworm-contagion. At the end of our interview she admitted somewhat reluctantly that four years ago several of her children had suffered from ringworm, and that she had attended to their heads. She was not aware at the time that she had contracted any disease, and it was not till three years later that the first bald patches showed themselves on the scalp. I mention this case because it is one of many in which the first evidence seemed opposed to the theory, and in which it was only after some insistency that the facts came out. In many patients there is a great desire to forget and to conceal the occurrence of ringworm in the family.

My next case is a more definite one. A young surgeon wrote to me that he had been suffering for some months from Area of the beard, the cause of which he could not conjecture. When he came to me a few days later my first question of course was, "Have you had ringworm?" To which his reply was, "Yes; I had a bad attack four years ago, in the beard, which I thought I had caught at a barber's shop; I found plenty of cryptogam with the microscope." It appeared that he had cured himself with much trouble, by epilation,

&c. Three years elapsed before the alopecia appeared. The latter was in a most typical condition, the patches being smooth and bald, and well-defined. The ringworm had been limited to the beard, and the alopecia was as yet restricted to the same position.

No. XV.—*Very severe Herpes frontalis in a gentleman who was taking full doses of arsenic for Psoriasis—The eyeball affected and exceedingly painful.*

Mr. W——, æt. 45, suffered a most severe attack of herpes frontalis. He was taking at the time that it began Liquor Sodæ Arseniatis m x; with Liq. Arsenicalis, m iij, t.d. He had taken this drug since June 23rd, and the herpes began on July 23rd. The herpes was on the right side, and a few vesicles came on the tip of nose. The whole right forehead was covered with vesicles. The pain was chiefly in the eyeball. On Thursday, July 24th, he had called complaining of pain in the eye. I did not then observe any herpes, and told him to have removed a tooth which he thought was causing the eye-ache. During the next night the eye-ache was “terrible.” Mr. W—— says that he never had such pain, and that he thought he should lose his senses. Antipyrin and morphia were at first of no effect, but on the third night a subcutaneous injection of the latter procured sleep. On inquiry as to the character of the pain, Mr. W—— says that it was a grinding pain as if the eyeball would burst. It was in the eye and all round it.

It appears that on the date of his visit to me for the “neuralgia,” and when I advised removal of the tooth, there were, he says, some vesicles just appearing on his forehead, but as the skin on which they occurred was already inflamed by psoriasis I did not notice them.

It is worthy of note that Mr. W——, who has long suffered from psoriasis, has taken arsenic often before, and for long periods. He never, however, took it in such large doses as those which I ordered on June 24th. He never before had herpes.

No. XVI. — *Supposed increase of Cancer in New Zealand—A fallacy.*

I have repeatedly done my best to attract the attention of cancer-statisticians to what appears to me an all-important fallacy. I allude to the fact that as cancer is a disease of senility,—a mode of natural death in old age,—we ought to expect an increase in the number of deaths in ratio with the increasing average longevity in any given district. The greater the number of those who have lived to fifty, the greater will be the number of cancer deaths. Our domestic animals illustrate this well. Our dogs, cats, asses, and horses die of cancer; our sheep and oxen never.

An interesting paper by Dr. Gordon Macdonald, in *The New Zealand Medical Journal* for July, has afresh awakened my interest in this question. Dr. Macdonald is alarmed at the increase of deaths from cancer in New Zealand. The facts show that it has doubled in ten years, although the population increase has been but one-fifth. No figures are given as to the total number of those who now die after fifty as compared with that of the earlier period. It may easily be the fact that the colony is now for the first time reaping its crop of aged persons. In former years it received many young immigrants, and it is not improbable that the number of aged was ten years ago much less than it now is. In other places where cancer is said to be increasing, it is well-known that longevity has also increased. I am confirmed in the opinion just expressed by observing that Dr. Macdonald's tables do not show any material increase until we reach the age of forty-five years, and that by far the most marked increase is after the age of sixty. It may seem a paradox, but it is nevertheless true that a high mortality from cancer is very creditable to the sanitary conditions of the community in which it occurs. Nothing but good surgery can in any degree restrain its increase, for all the successes of the sanitarian tend in the opposite direction.

A CATECHISM OF SURGERY; WITH CASES FOR DIAGNOSIS.

No. XLV.—*Festination, Westphal's Symptom and Clonus.*

1. What is "festination" ?
2. In what disease does it occur ?
3. What is Westphal's symptom ?
4. What is "ankle clonus" ?
5. What is the meaning of the word "clonus" ?
6. What condition allied to ankle clonus is often discovered by patients themselves, and what does it imply ?

ANSWERS.

1 and 2. "Festination" or "hurrying" is a name given to the half-running gait which is often seen in paralysis agitans. The head is thrown forwards and the body bent, and the patient begins to run under the necessity of regaining his centre of gravity.

3. "Westphal's symptom" is what is usually known as loss of patellar reflex. It was first observed by Westphal.

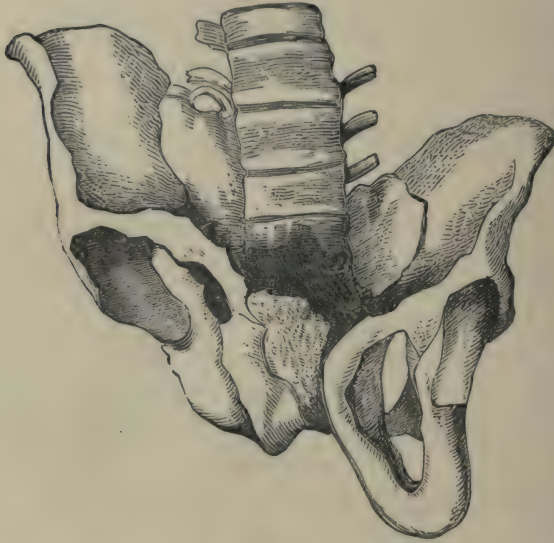
4. "Foot clonus," "ankle clonus," "reflex clonus," "foot trepidation," and "turning-lathe movement," are names given to the rapidly repeated movements of the foot which, under certain conditions, may be induced by forcibly extending the tendo achillis. It is observed in various forms of paraplegia, and in association with increase of patellar reflex. Hughlings Jackson has observed it as a temporary condition immediately after an epileptic fit.

5. Recurring and tumultuous movements.

6. Patients often observe that if whilst sitting the foot is pressed firmly in the tip-toe position, the calf at once passes

into clonic spasm, with very rapid lathe-turner's movement. The symptom is usually of no great consequence, but may imply spinal defect.

No. XLVI.—*Specimen for recognition.*



1. What is the condition shown in this wood-cut?
2. What has been the nature of the accident which produced the displacement?
3. What should have been the treatment of the case?
4. Are similar conditions often met with in practice?

ANSWERS.

1. The wood-cut shows displacement of the whole of the os innominatum upwards. The iliac crest is at least an inch and a half higher on the right than the left side, and the same with the tuber ischii. The line of junction of the ilium with the sacrum is obliterated by the deposit of new bone.

2. The specimen is in the Musée Dupuytren at Paris. No history is forthcoming; but presumably the pelvis had been crushed with great violence.

3. If practicable, the displacement should of course have been reduced by drawing the limb downwards and fixing it by a long splint, pelvic bandage, &c.

4. Displacement of an entire os innominatum is a very rare accident. I have, however, treated more than one such in the London Hospital.

No. XLVII.—*A Case for Diagnosis and Treatment.*

A gentleman of 37 has for four years been passing at an average four quarts of limpid urine per diem. It has a specific gravity of 1005, or sometimes only 1002, and looks like spring water. It always contains albumen. He retains fair health, and has no dropsy. He has, however, acid dyspepsia, and is liable to most violent headaches with vomiting.

1. What name should be given to his chief symptom?

2. In what directions would you wish to make further inquiries?

3. How are the headaches to be explained?

4. What is the prognosis of the case, and what are its special dangers?

5. What treatment would you adopt?

ANSWERS.

1. The case is one of polyuria or diabetes insipidus. It is complicated by the presence of albumen, and probably by deficiency of urea.

2. A careful estimate of the quantity of urea excreted per diem should be made, for on this chiefly the prognosis will depend.

3. His headaches and sickness may possibly be of uræmic causation.

4. The prognosis is grave, notwithstanding the patient's appearance of good health, for a sudden development of uræmic symptoms may occur at any time. The patient is in danger of disease of the arterial coats and hypertrophy of heart. He may have brain symptoms—First, from rupture of a diseased artery. Secondly, from the direct influence of urea (uræmic coma).

5. The treatment should be by careful attention to the bowels and skin, an extremely quiet mode of life, avoidance of causes of catarrh, and a non-stimulating regimen (milk and vegetables).

No. XLVIII.—*The two forms of Hydrocephalus.*

1. Distinguish between external and internal hydrocephalus.

2. Which is the more common?

3. To whom are we chiefly indebted for knowledge on this point, and when did he live?

ANSWERS.

1. In external hydrocephalus the fluid is collected between the dura mater and the brain, in the arachnoid cavity.

In internal hydrocephalus the fluid distends the ventricles, chiefly the lateral ones, and the brain mass is spread out in a more or less thin layer over it.

2. Internal hydrocephalus is far more common than external. Many mistakes of observation have occurred in consequence of the thinness of the layer of brain matter covering the fluid. It is even doubtful whether any large external collections of fluid are ever met with excepting as congenital conditions.

3. Dr. Alexander Monro, in 1797, first proved that the ventricles communicated, and cleared our views on the point referred to.

No. XLIX.—*Cerebral Hemi-anæsthesia.*

1. What is meant by the term "cerebral hemi-anæsthesia"?

2. Where is the brain-centre for sensation placed?

3. What other symptoms attend the hemi-anæsthesia?

ANSWER.

Those who have investigated the localization of cerebral functions tell us that if a certain belt of fibres passing from the posterior part of the crus cerebri external to the optic thalamus be destroyed, loss of sensation on the opposite side will result. To this Dr. Ferrier adds that it is due to

the fact that the fibres in question are proceeding to the hippocampal region, and this latter he regards as the cerebral centre for sensation. In addition to the cutaneous anæsthesia induced by disease of this region there is also, adds Dr. Ferrier, damage to the special senses. Vision in the eye opposite to the lesion and on the same side as the anæsthesia is "seriously impaired, if not quite abolished." There is remarkable contraction of the field of vision, and difficulty in discrimination of colour. The defect of sight is confined to one side, and is a purely unilateral amblyopia or amaurosis. The other special senses, not excepting smell, are also diminished. This group of symptoms constitutes what is known as "cerebral hemi-anæsthesia."

No. L.—*A Case for Diagnosis.*

A Welsh farmer, of 38, apparently strong and well, has had three or four attacks of inflammation of his right eye, and one in the left. The attacks have been almost painless, but have left minute patches of haze at a little distance from the corneal edge. His attacks have always been produced, as he thinks, by exposure to cold, and the worst came from having had his hair cut. He has lost four brothers and sisters from consumption. In early life he was very liable to quinsy, but has had none since he let his beard grow. He is not liable to cold extremities, nor to chilblains. With the attacks of inflammation of the eye he has more than once had discharge from one or other ear, with deafness and great sense of fulness but without pain.

1. What is the nature of the ophthalmia?
2. With what forms of diathetic tendency are such attacks usually associated?
3. In what do the attacks differ from typical catarrh?
4. What should be the measures of treatment?
5. To what named malady is the case allied?

ANSWERS.

The disease would appear to be of a somewhat catarrhal character—that is, a consequence of exposure to cold; but it differs from typical catarrh (with coryza), in that the cold has

always been applied near to the part affected, and that the resulting inflammation has never been symmetrical. In its transitory character it has conformed to the law which regulates all catarrhal inflammations. There is some fear, should the disease be neglected, that it may lapse into what is known as Recurring Cyclitis. No doubt the history of family tuberculosis is important, for it is one which is frequently present in cases of the last-named disease.

The indications for treatment are obvious. To let the hair grow freely both on scalp and face; to carefully avoid all undue exposure to cold; to take tonics and cod liver oil, and to live liberally. For the attacks of ophthalmia and external otitis, an ointment containing two grains of yellow oxide of mercury to the ounce will probably be best.

It is desirable to inquire carefully whether there be any gouty predisposition. Relapsing cyclitis is usually either gouty or scrofulous, or both.

No. LI.—*Cowper's Glands and Bartolini's Glands.*

1. Is the name "Cowper's Glands" correctly applied to the glands of Bartolini (or Duverney) ?

2. Of what are Bartolini's glands the analogues (in the male) ?

3. Do the lower animals possess these glands ?

4. What is the probable use of their secretion ?

5. Is their presence invariable ?

6. What becomes of them in age ?

7. Describe their exact anatomical position.

ANSWERS.

1. Scarcely. Cowper in 1697 described in the male (already known to Columbus) the glands which bear his name: Duverney in the middle of the eighteenth century discovered his vaginal glands in the cow; and Bartolini, following up information given by Duverney, found them in the human female soon afterwards.

2. They are unquestionably the analogues in the female of "Cowper's glands" in the male.

3. It is believed that all animals in which the females have these vaginal glands, the males possess the glands of Cowper.

4. They secrete freely a mucus which lubricates the parts and dilutes the semen, and they probably exercise in coition a similar function to that of the salivary glands in eating.

5. They are not invariably present, and sometimes one only can be found. The same is true of Cowper's glands.

6. In advanced age they diminish in size and may wholly disappear.

7. The following is Tiedemann's description of them:—

“These glands are situated at the entrance of the vagina, beneath the skin covering the inferior part of the labia. They are covered by the superficial fascia of the perineum, and by the fibres of the constrictor vaginae. They here occupy a space included between the lower end of the vagina and the ascending ramus of the ischium, and the ramus of the clitoris and erector clitoridis muscle. The glands lie in very loose cellular tissue, the removal of which requires very careful dissection in order not to cut away the glands with it. They are bean-shaped. Their long diameter varies from 5 to 10 lines: their transverse diameter from $2\frac{1}{2}$ to $4\frac{1}{4}$, and their thickness from $2\frac{1}{4}$ to 3 lines” (p. 13).

No. LII.—*Diseases of Bartolini's Glands.*

1. Mention the diseases to which Bartolini's glands are liable.

2. To what condition is the term “vaginal ranula” applicable?

3. Under what conditions of life is vaginal ranula most frequently met with?

4. What is the treatment required?

5. Are Cowper's glands in the male, and their analogues in the female, of importance in reference to gonorrhœa and gleet?

ANSWERS.

1. The duct may be blocked or obliterated and a cyst may form from accumulation of secretion behind. Acute inflam-

mation may occur, and an abscess with fetid contents may result. The gland may be affected in gonorrhœa and secrete pus.

2. The term "vaginal ranula" might very suitably be applied to cases in which, without inflammation, the glands become dilated in large cysts containing glairy mucus.

3. Their subjects are almost invariably young newly-married women.

4. It is not usually necessary to excise the cyst, but sufficient to lay it freely open and apply lunar caustic to the interior.

5. Cowper's glands no doubt sometimes suffer in gonorrhœa, and their analogues in women probably usually do so. They are inaccessible to injections, and chronic disease is therefore very likely to persist in them. It is not improbable that Bartolini's glands may often be the source of contagious secretions in women who believe themselves quite free from vaginal discharge.

No. LIII.—*On Symptoms in cases of Deafness.*

1. If a patient cannot hear a watch when pressed on the forehead or held between the teeth, what does the inability imply?

2. Conversely, if the watch held near the ear is not heard, but is so as soon as the forehead is touched, what is the cause of the deafness?

3. How would you ascertain whether the Eustachian tube is free?

4. What condition observed in the external ear implies blocking of the tube?

ANSWERS.

1. It implies disease in the internal ear, or of the nerve trunks or centres, and it excludes obstructions of the external meatus or Eustachian tube.

2. Obstruction of the meatus usually renders the sound-wave transmitted by the bones more easily perceptible, as may easily be proved by pressing down the tragus. It shuts the door and prevents the sound from escaping. Thus if a patient

cannot hear a watch held in the air a few inches from the meatus, but hears clearly directly it touches the head, the diagnosis of obstruction of the meatus is evident.

3. The patient should be made to close his nostrils, take water in his mouth, and then swallow. This will cause a distinct thud in the ear if the tube is not closed. Or he may be told to close his mouth and nose and then attempt forcible expiration. Or "Pollitzer's bag" may be used, by which the surgeon blows air into the nostril at the same moment that the patient by the act of swallowing opens the faucial orifice of the tube. The surgeon, by means of another tube from the patient's ear to his own, may himself hear the sound produced by the filling of the tympanum.

4. A much depressed membrana tympani, as ascertained by the speculum, implies a blocked Eustachian tube.

No. LIV.—*Acromegaly*.

1. What is the condition to which the name "*Acromegaly*" has been applied?

2. With what internal lesion is it often associated, and what is the probable nature of the connection?

3. Are other parts overgrown as well as the bones?

4. Is it attended by failure of general health?

5. What is its clinical course?

6. Distinguish between *acromegaly* and *osteitis deformans*.

[See ARCHIVES i. 141.]

ANSWERS.

1. The pathological marvel to which this name has been given (by Dr. Pierre Marie, who first observed it) is attended by enlargement of the extremities, head and face, hands and feet. These grow in all dimensions until they are quite disproportionate to the rest of the body.

2. The subject of *acromegaly* becomes unable to wear the hats, gloves, and boots which formerly fitted him. The hands are conspicuously big, the fingers being very broad. The face looks large and coarse, especially its lower part.

The pituitary body has been repeatedly found much en-

larged; but it is more probable that this enlargement is a part of the disease than its cause.

3. Yes; the skin and its appendages grow as well. The lips become thick, and the skin of the scalp may be thrown into thick folds.

4. It is not at first attended by definite failure of health, but by degrees cachexia usually supervenes.

5. Dr. Marie believes that the ultimate prognosis is bad; but his fears are possibly a little exaggerated.

6. Osteitis deformans is a disease of the osseous system generally, and not of the extremities. There is loss of stature. There is no enlargement of the soft structures. It is a form of chronic inflammation, whilst acromegaly is a lesion of growth.

No. LV.—*Spina Bifida.*

1. What is a spina bifida?
2. What different forms of spina bifida are met with?
3. In what part of the back is it most frequent?
4. Mention some of the complications of spina bifida.
5. If the subject of spina bifida attain adult life, what inconveniences may be present?
6. What methods of treatment may be adopted?

ANSWERS.

1. A congenital protrusion in connection with the spinal cord.

2. Protrusion of membranes only; of membranes with the cord or nerves; of the membranes and cord with dilation of central canal. These are named meningocele, meningo-myelocele, and syringo-myelocele respectively. The second form is by far the most common, and the last is exceedingly rare.

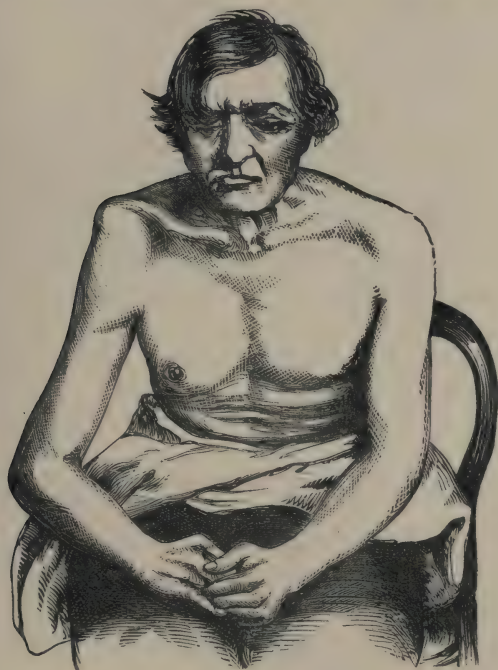
3. The lumbo-sacral region is the part usually affected.

4. When the nerves are involved there is often talipes or some form of paraplegia. Hydrocephalus is not uncommon.

5. If the patient survives, he may suffer from permanent incontinence of urine and fæces, and possibly some weakness of the legs. Some form of talipes may be present.

6. Injection of solutions of iodine is the only suitable treatment if interference is decided upon, but it may be questioned whether it is not better to avoid it. Precisely the cases suited for operation are those which may do well without. If the tumour be covered with healthy skin and plenty of fat, survival may be expected.

No. LVI.—*Diagnosis of dislocation at shoulder.*



1. Describe the conditions presented in this wood-cut.
2. What is the diagnosis?
3. What is the usual position of the bone in dislocation into the axilla?
4. How would you distinguish between a sub-coracoid and a sub-glenoid dislocation?
5. Among the differential symptoms mentioned, which is the principal?
6. Which form is indicated by the wood-cut?

ANSWERS.

1. The rotundity of the shoulder is lost. Instead of the usual roundness there is some appearance of hollow at a little distance under the tip of the acromion. The acromion projects, and it with the clavicle is pushed upwards. The elbow slants away from the side, and the upper arm looks as if it were longer than on the other side.

2. It is clearly a dislocation into the axilla.

3. The bone may be either under the glenoid fossa or on its inner side under the coracoid process. The former is very common and the latter exceedingly rare.

4. In sub-glenoid the arm is of necessity considerably lengthened—an inch and a half. The hollow under the acromion is well marked, and most conspicuous at a little distance below that part. The fulness under the clavicle is much less than in sub-coracoid.

5. By far the most important symptom is the increased lengthening in sub-glenoid. In sub-coracoid there is little or no increase in length.

6. In so far as this wood-cut goes, all the conditions displayed indicate a sub-glenoid displacement.

No. LVII.—*Case for Diagnosis.*

An elderly man has a large ulcer which has destroyed half his face and is still spreading. It has been present twenty years or more, and has not injured his health.

1. What is the nature of the disease, and with what may it be confounded?

2. On what is your diagnosis based?

ANSWERS.

1. Such an ulcer can only be a *rodent cancer*. It might be confounded with lupus or with syphilis.

2. The long duration, slow spreading, and good health of the patient taken together, make it certain that it is not syphilis. The depth of the ulceration excludes lupus, which is a disease of the skin, and never destroys the bones of the face.

The age of the patient is also against lupus, which usually, though not invariably, begins in the young, and is cured as age advances.

No. LVIII.—*Contracted fingers, &c.*



1. Describe the conditions shown in the above wood-cut.
2. What is the disease named which is here illustrated?
3. Mention its supposed causes?
4. In which sex is it more common?
5. What is its treatment?
6. Does it ever occur in the feet?
7. Is it ever met with in the young?
8. When did Dupuytren live?

ANSWERS.

1. In each hand there is puckering in the structures of the palm, especially near to the ulnar side. The little finger is strongly flexed.

2. Dupuytren's contraction of palmar fascia.

3. The tendency to it is hereditary in certain families. There is often a history of gout. Its exciting cause is the use

of tools or of anything which presses upon the structures of the palm.

4. It occurs almost exclusively in men, but has been seen exceptionally in women.

5. Since it depends upon contraction of bands of fascia, the treatment consists in the subcutaneous division of those bands. The muscles are not implicated and do not need division.

6. It is very rare in the feet, and seldom advances to any high degree.

7. It never commences before middle life, and is usually distinctly senile.

8. Baron Dupuytren was born in 1777, and died in 1835.

No. LIX.—*The proper duration of Lactation.*

1. What ought to be the duration of lactation when mother and child are healthy?

2. Does any harm accrue to mother or child, or both, from prolonged lactation?

3. Give facts from the lower animals.

4. How long is it possible to prolong lactation?

5. Mention some indications for the termination of lactation.

6. Is prolonged lactation a legitimate and suitable precaution against too rapid child-bearing?

7. Does lactation always prevent conception.

ANSWERS.

1 & 2. It is probable that the answer to these questions depends almost entirely upon the feeding and health of the mother. A healthy lactifer, well fed, may continue to supply good milk for indefinite periods. Under these conditions, no harm will accrue either to mother or child.

3. Some of the lower animals (sheep for example) suckle their young till more than half-grown. Cows, if well fed, bear prolonged milking without injury. In most of the lower animals the lactation period is, in ratio with growth of the young and duration of life, much longer than that now usually allowed to women.

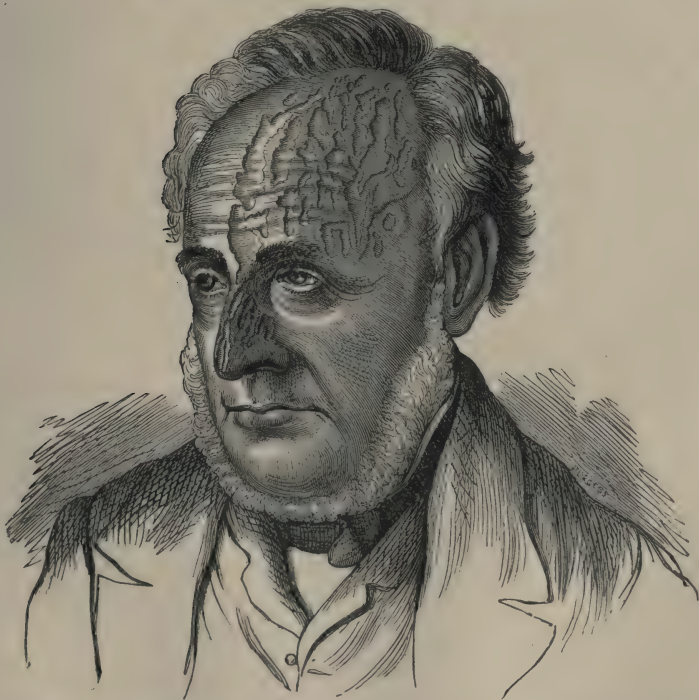
4. The duration of lactation cannot be prolonged indefinitely unless the ovaries have been removed; but under proper management it might probably easily be double what is now usual. Mahomet's laws required that a mother should suckle for two years (and abstain from intercourse).

5. Lactation should end if, in spite of liberal feeding, &c., the mother's health suffers; if menstruation has been resumed or pregnancy has occurred; or lastly, if the milk is poor and the infant suffers.

6. Yes; if the mother's surroundings be favourable and her milk good.

7. No. As is well known, it does not always prevent menstruation. When menstruation occurs, lactation as a rule should be stopped, and the occurrence of conception becomes possible.

No. LX.—*Case for Diagnosis.*



1. The conditions intended to be shown in the above wood-

cut are a series of scars arranged in a somewhat linear manner on the forehead, temple, and side of nose. What disease do such scars denote?

2. By what nerves has the disease been located?
3. What is probably the essential nature of herpes?
4. Does herpes frontalis differ in any way from common zoster?
5. What other lesions than those on the skin attend herpes?

ANSWERS.

1. The scars arranged in the manner shown denote conclusively the occurrence of a severe attack of herpes zoster frontalis ("herpes ophthalmicus"). No other disease could produce scars so definitely unilateral.

2. It would appear that the whole division of the fifth nerve was implicated. The scars occur even on the tip of the nose, showing that the oculo-nasal twig did not escape.

3. A neuritis attended by an eruption; the eruption being due to implication of the end organs of the nerves.

4. No, they are the same malady, due to the same causes, and differing only as to the special nerve affected.

5. Herpes is usually restricted to the sensory nerves; but the organs of special sense may suffer. Now and then muscles are implicated, and occasionally possibly subcutaneous tissues, fascia, &c. In herpes ophthalmicus the eyeball often suffers as a whole.

ARCHIVES OF SURGERY.

APRIL, 1891.

CASES ILLUSTRATING THE HEREDITARY TRANSMISSION OF SYPHILIS.

THREE cases, in one family, which I have recently had under observation, are of great interest in reference to our knowledge of inherited syphilis. They place in a striking light the possibility of entire absence of symptoms in the infantile period. They also seem to teach that inheritance may be possible at longer periods after the original disease in the parents than is usually the case. On neither of these points is their testimony novel, but it is nevertheless, I think, of sufficient value to make them worthy of narration.

Mrs. R——, in the first instance, consulted me about herself. She was a delicate-looking woman, and had suffered for many months from glandular abscesses in the right side of her neck. There was extensive ulceration, with considerable thickening of the parts. The edges of the ulcer were undermined; the conditions very closely resembled those present in struma, and no thought of syphilis crossed my mind. She was already residing at a healthy seaside place, so that I could not suggest any improvement in this respect.

About four months after Mrs. R—— had first consulted me, she brought with her her eldest daughter, a girl of twelve. This child was said to have always enjoyed excellent health, and had never had any illness excepting scarlet fever. She was a well-grown girl, and presented no peculiarities of teeth

or physiognomy, excepting great over-development of the frontal eminences. She suffered, however, from phagedænic ulceration of her soft palate, and the conditions presented made me feel certain that she was really the subject of inherited syphilis. I ascertained that she had been born about a year after her mother's marriage, and had had no infantile symptoms whatever. I never saw her father, but Mrs. R—— told me that he was a very robust man, and had always been so since she had known him. Guided by the insight obtained from the daughter's case, I at once prescribed for the mother on the supposition that what looked like struma was really syphilis, and with the result that the ulcerations which had resisted all other kinds of treatment very rapidly healed. The daughter's throat was treated as usual by the iodide of potassium internally, local applications of iodoform, and repeated cauterizations by the acid nitrate of mercury; but although my recommendations were most carefully and ably carried out by the local practitioner in charge, we had great difficulty in stopping the disease, and did not obtain cicatrization until almost the whole of the soft palate had been destroyed.

Towards the end of the treatment of her eldest daughter's case, Mrs. R—— brought to me a younger daughter. This girl was rapidly becoming deaf. She had been for two months under the care of a specialist, in the belief that the ears were not in my line. Her case was, however, a typical one of that form of deafness which occurs in inherited syphilis. Both ears were equally affected, and in the course of two or three months, without any changes which could be ascertained by examination, she became almost totally deaf. This girl was six years of age, and although remarkably well grown, she had not yet cut her upper incisor teeth, so that I cannot speak as to whether or not they may present any peculiarities. Her physiognomy certainly showed none, with the exception that, as in her sister, the frontal eminences were very conspicuous, like budding horns. She was stated to have been a very healthy infant, and had suffered from nothing excepting a sort of relapsing urticaria.

Having thus, from the nature of the disease with which the

two sisters were affected, and from the rapid cure of that from which the mother suffered, obtained conclusive evidence that all three were the subjects of syphilitic taint, I made further inquiries as to the family history. The mother assured me that excepting the ulcers in the neck she had never ailed anything during her married life, and I feel sure that she was quite innocent as to any suspicion of the real nature of the malady. Of course I did not ask her any direct questions, and, as has already been said, no opportunity occurred of seeing her husband. Inasmuch as her first-born child was clearly the subject of inherited taint, probably the father had suffered from syphilis within two years of his marriage, although, at that time and since, wholly free from symptoms. The infected fœtus no doubt contaminated its mother, and she, although never manifesting any secondary symptoms, and although never knowing that she had been ill, developed tertiary gummata ten years later. In the interval she had borne several children, of whom one, a boy now eleven, had always been perfectly healthy. Two had died, one still-born, and one, a seven-months' child, of convulsions at the age of four months. I could not elicit on the closest inquiry respecting the three living children, and the one which had died, that any one of them had exhibited in infancy any symptoms whatever.

It will be seen that the girl who is the subject of deafness is seven years younger than the one in whom the phagedæna of the palate occurred; thus proving that the power to transmit the taint of syphilis must have persisted during this length of time in one or both of the two parents. My impression is that this persistence is most probably in the mother. In her the taint had been received probably a year or two later than in the father, and she had had no treatment whatever. In a note at p. 66, ARCHIVES, Vol. II., I have discussed the question as to whether women are not liable to transmit syphilis during much longer periods than men, and answered it, though with some diffidence, in the affirmative. In that case, a mother who had been the subject of primary syphilis bore tainted children to a healthy man eight years after the acquisition of her disease. I have

certainly never known a case in which a man marrying eight years after his syphilis became the father of a syphilitic child. I have never known such a period approached, and am accustomed to tell men with confidence that they may marry at the end of the second year. Very few indeed have been the exceptions in which I have had any reason to doubt the safety of this rule. In the case of women, I have repeatedly known the power to transmit the disease last much longer. It must be remembered, however, that women as a rule seldom get the long and efficient treatment which men willingly submit to, and that not unfrequently the taint, being wholly unrevealed and unsuspected, may escape treatment altogether.

It may perhaps be for the reader's convenience that I should state in the form of propositions the facts which seem to me to be proved by the cases under consideration:—

1st. That a mother may receive syphilis by foetal contamination and never show any symptoms until the formation of a glandular gumma thirteen years later.

2nd. That a mother the subject of syphilis by conception, and having had no treatment, may transmit syphilis to an infant born seven years after the one which infected her.

3rd. That a succession of children really the subjects of taint, as definitely proved in two of them, may pass through infancy without the slightest manifestation of it.

4th. That the physiognomy of inherited syphilis and the notched teeth may be wholly absent.

5th. That considerable value for purposes of diagnosis attaches to the prominence of the frontal eminences.

6th. That the conditions of phagedænic destruction of the soft palate in young people, and of symmetrical deafness, are both of them really consequences of inherited taint, and may be trusted as, in themselves, constituting proof of it. Had either of these girls come under care without the corroborative testimony from her sister's and mother's ailments, it might easily have been urged that the case was exceptional to the statement that these maladies are always of specific origin.

The cases of Mr. and Mrs. B—— and their infant are of

some interest in connection with the preceding narrative. Mr. B—— married on November 14, 1889, with the full permission of a very competent specialist. He had, however, only six months before his marriage been under treatment for a gleet and for some eruption on one thigh. With these symptoms there went also a sore throat, and although it was fully acknowledged that he had had complete syphilis four years ago, the distinguished specialist just alluded to told him that he thought he must have had some recent contagion. Mercurial inunction was used, and, as the symptoms disappeared very quickly and completely, I suppose his adviser must have changed his opinion as to there having been a recent infection, for he gave him, as already said, permission to marry soon afterwards. At the time of his marriage Mr. B—— appeared to be in excellent health, and he remained so ever afterwards. He was liable to attacks of slight balanitis. He married a widow lady a few years younger than himself, who was in excellent health. In the beginning of April, that is some six months after marriage, Mrs. B——, who was then pregnant, was brought to me covered with a syphilitic rash. It was stated that the eruption had come out suddenly a fortnight before, after taking a bath. She had suffered from leucorrhœa, and had some irritation on the genitals, but I did not detect any definite remains of a chancre. She was six months pregnant, and in good general health. At this date I examined Mr. B——, and found not the slightest traces of syphilis about him. I advised both husband and wife to take mercury. In the case of Mrs. B—— a slight pytalism resulted, and her eruption disappeared entirely. From that time forward she had no other symptoms; and I believe that she did not take her pills with any great regularity. On June 2nd her infant was born, and proved to be a fine baby. It was brought to me, however, six weeks later on account of supposed paralysis of the left arm. I found that the inability to use the arm depended upon tenderness about the epiphyses. There was distinct swelling above and below the elbow. The child had bad snuffles, and its finger nails looked pinched and convex. It was beginning to waste; and

was very fretful. I of course at once prescribed for syphilis. The treatment agreed well, the periostitis soon disappeared, and in the course of a month the infant was again thriving. No relapse of symptoms occurred.* The chief point of interest in this case was, as to whether or not the husband had had a second attack of syphilis. If he had not, then his wife and child suffered in consequence of disease which had occurred four years previously. He was not aware of having had any second chancre, but he freely admitted frequent exposure to risk, and only a few months before his marriage, after two or three years of immunity from his first attack, he had been under treatment for gleet, eruption, and sore throat. My impression is strong that in all probability he had had a second infection, and that the permission to marry so soon after suspicious symptoms was not judicious. It is further, I think, highly probable that the disease in his wife was due to direct infection from a primary sore, rather than to foetal contamination. She suffered from vaginal irritation, and had a roseolous eruption which was distinctly of a secondary kind. It is not, I think, usual, in cases of contamination of the mother by the foetus, that symptoms of the secondary group should occur. The mother more usually, as in the preceding case of Mrs. R——, remains apparently in good health, but develops tertiary symptoms at some later date.

It is not without its interest to note that had the husband in this case preferred to conceal the fact that he had had symptoms within a year of marriage, and to deny exposure to risk, we should have been obliged to admit the case as one proving that it is possible for one who had syphilis four years ago, and had been in good health three years, to beget a syphilitic child and to contaminate his wife. Mr. B——

* It may perhaps be well to give the details of the prescription, which in this case suited admirably :

Iodide of Potassium	gr. $\frac{1}{2}$.
Sol. Bichloride of Mercury	m x.
Spirits of Wine	m iv.
Water	3 i.

This dose the infant took three times a day, without any disagreement, continuously for about two months.

when I saw him was absolutely free from symptoms, and showed only the scars of rupia which had occurred four years ago. Now nothing is more common than for men to willingly admit having had syphilis at some distant period, and yet try to conceal the fact of recent exposure; especially if the latter have occurred during a marriage engagement or under circumstances which they think imply special disgrace. The more distant the contagion can be placed, the less, as a rule, is the reluctance to acknowledge it. Hence a very frequent source of fallacy in the clinical histories of syphilis.

The occurrence of anything of the nature of glandular gummata in the tertiary stage of syphilis is in my experience very rare. In the first of the two narratives just given we have one of the best examples of it which I have ever seen. A large mass of glands in the neck had broken down and involved the cellular tissue just as seen in struma. In ARCHIVES, vol. i. p. 73, I noticed a very remarkable case recorded by Dr. M'Call Anderson, in which an enormous mass of glands had disappeared under specific treatment, and in my last issue (p. 204) the subject was again referred to. It seems worth while to append the following fragment in reference to it.

A girl who was at Moorfields some years ago, with undoubted inherited syphilis, presented a large tumour in her neck. It was adherent to the neighbouring parts, but it was smoothly rounded and tense, and there was at first no evidence of its being made up of several glands. It had increased rather rapidly during about a month. Under iodide of potassium it diminished very much in a week, and then it became clear that it was glandular. As the infiltration around it disappeared, a whole cluster of enlarged glands were to be recognized. It was no doubt a lymphatic gumma. It wholly disappeared under treatment.

THREE CASES OF ACROMEGALY.

Illustrating the stage of Premonitory Symptoms.

I HAVE had three cases of acromegaly under my observation during the last year. The first case was that of a lady, whom I had seen on a single occasion three or four years ago, without then making any diagnosis beyond that of rheumatism. This lady has recently come under the care of my friend Dr. Hughlings Jackson, by whom she was brought back to me as an example of Dr. Pierre Marie's malady. Such she now undoubtedly is, her extremities being conspicuously enlarged, and her face lengthened. As she is now Dr. Hughlings Jackson's patient, and he will probably publish the case, I shall not give further details as to her present condition. It may be of interest, however, to transcribe from my note-book the particulars as regards her premonitory symptoms, as they were observed four years ago.

"Mrs. S——, æt. 32, suckling her child six months old, was sent to me November 15, 1883, by Dr. Cæsar, of Tottenham. She complained of intense pain from the elbows downwards, and the right fingers were flexed into the palm. The other hand was sometimes affected in the same way. There was sensation of 'tingling numbness and intense burning' in the right hand. She had twice been threatened with rheumatism, but had then no joint affection. She had always been a chilly subject, and often thought that her blood did not circulate properly. She had been well at the beginning of her lactation. The hand sometimes became 'chalky looking,' white in colour, and she could not tell whether she had anything in her fingers or not. The first time she felt this was after sleep, when she thought her circulation had stopped. There was no difference between the two radials. She was often chilly and afterwards flushed."

My second case was that of a gentleman named Mr. A—— G——. Mr. G—— is aged 40, and has been married fourteen years. I first saw him in August, 1889, and again in June, 1890. He consulted me on account of defects of circulation in the extremities, with peeling patches in the ends of the fingers. On every occasion that I saw him I noticed the extraordinary size of his fingers and the length of his face, and several times pressed him as to whether he had not noticed any increase in their growth recently. This at first he denied, but on a later occasion he admitted that the size of his gloves and shoes had been considerably increased. He tried the experiment with some old boots, and found that he could not put them on. He brought me some photographs taken at intervals several years ago, and from them there could be no doubt that during the last six years the size of his face had conspicuously increased, especially in the lower part. It appeared, however, that he had always had a somewhat heavy lower jaw, and he said that his father, like himself, had large hands. The great size of his tongue was always a feature which attracted my attention. His countenance remarkably resembled that of Mr. C. B. (see ARCHIVES, i. p. 141), the skin of his forehead being coarse, thick, and thrown into folds. The measurement of Mr. G——'s knuckles was $9\frac{3}{4}$ inches. The symptoms for which Mr. G—— consulted me were the following:—He complained that he was liable to have the blood leave his hands and feet, and said that he felt weak and faint when it did so. He said that he was losing confidence in himself, and was becoming nervous. He was in the habit of rubbing the back of his neck violently when at business, in order to "revive his brain," as he said. In consequence probably of the constant disturbances in his circulation, the pulps of his fingers had become dry and cracked. He had not experienced any severe headache, but, like my patient Mrs. A——, he had a longing for quiet and holiday. His tongue was habitually furred and white, although he had a good appetite. He suffered somewhat from piles.

It will be seen that in these two cases the premonitory

symptoms were not dissimilar. They consisted chiefly in derangements of circulation in the extremities with lassitude.

My third case is that of the widow of a Welsh farmer, who was sent to me by Dr. W. Evans, of Anglesea.

Mrs. H—— first came to me in May, 1887. She fancied she had gout, but I could find no proof of it, and prescribed a tonic. I did not then notice anything further than that her features and hands looked coarse and large.

In August of the same year she saw my son Procter, and had a polypus removed from her right nostril.

Mrs. H—— came to me again three years later (September, 1890), and I then at once recognized that she was the subject of acromegaly. She said, when I suggested it, "Oh, yes; I have been growing very much; my hands and feet are getting much bigger than they were." The enlargement was symmetrical in all parts, and appeared to shade off insensibly into the parts not involved. Her wrists and forearms were very large, and so was her whole head, without any bulgings: Her mouth and lips showed the condition most conspicuously. Her skin was very coarse and greasy. It was also constantly moist with perspiration. She was wearing large cloth shoes which laced, but which she could not nearly close. She considered herself rheumatic, but there was no stiffening of any joints. Her chief suffering was from facial neuralgia, which occurred in violent paroxysms, often keeping her awake at night. It was chiefly, but not exclusively, in the left side. She had not menstruated for three years or more. Her age was 46. Her legs, like her forearms, were very large. It is to be understood that the overgrowth was of skin and subcutaneous tissues quite as much as of bones. Although her face looked so large, and her lips especially, yet I could not on examination from within the mouth appreciate any thickening of the lower jaw. The left coronoid process appeared to be enlarged, but not much. The girth of her hands around the knuckles was nine inches and a half, and that of her index fingers three and a half.

Mrs. H—— was a large, coarsely-built woman. She said that she had of late got weaker, but still attended to her household duties. The slightest exertion made her perspire.

A MOST REMARKABLE INSTANCE OF KERATOSIS OF THE PALMS AND SOLES.

I DESIRE to rescue from that oblivion which has overtaken not a few of the excellent clinical observations of our forefathers a most remarkable case. It is that of a man who throughout the greater part of his life suffered from an affection of his palms and soles, attended by thickening and overgrowth, and finally by the development of outgrowths almost polypoid. The condition of things finally assumed is well shown in the lithographs which I have copied from the original Memoir. I have never myself seen any similar case, I mean not one which had attained anything like a similar development. I showed the portraits before the Dermatological Section at Berlin, where I believe they were quite new to all who saw them. I did not on that occasion get from my friends any hints either as to the true nature of the malady or as to the existence of other recorded examples of it, nor have I met with any reference to this case in our systematic works on Dermatology. Yet it is little more than half a century since the case was published in a well illustrated quarto monograph, by an authority of no less distinction than Dr. Wilhelm Sömmerring, of Frankfort. The patient had, I believe, never been seen by Dr. Sömmerring himself. He had been under the care of Dr. J. D. J. Behrends, to whose zeal we are indebted for the preservation of portraits done in oil by an artist named Bager. This was thirty years before their publication. Dr. Behrends died in Salzburg, about 1823; and the paintings then fell into the hands of his son, who showed them to Dr. Sömmerring, and at the same time communicated the particulars of the case. Unfortunately the latter were supplied in part from memory. They are not as complete as could be wished; nor is there

extant, so far as I am aware, any sequel to the case. The patient was still living when it was published. Dr. Sömmerring in recording it, enters at considerable length into the literature of ichthyosis, to which he supposes the disease to be allied.

The following are the chief facts in reference to the patient, which were supplied by Dr. Behrends, junior. He was a man who at the time the portraits were taken was aged fifty-three. He stated that he remembered in early boyhood to have been troubled with rounded swellings in his soles and palms. These had throughout life given him considerable annoyance by becoming painful during his work. The remarkable out-growths which had finally disabled him had developed chiefly during the last three years.

The man was apparently healthy. He was well-made and muscular, and had throughout his life scarcely ever suffered from illness with the exception of an attack of small-pox at the age of seventeen. The tumours, which are described as being chiefly situated on the inner aspects of the hands and feet, were of a greyish white colour and very sensitive. They were said to be much more painful during damp weather than when it was dry. They readily bled when small incisions were made into them. The growths extended from the nails along the anterior surface of the fingers, and on the feet as far back as the heels. The nails were distorted and enlarged; and those of one hand especially were greatly hypertrophied and curved.

The above are all the important particulars which I have found on record, and it is scarcely worth while that I should attempt any detailed description of the appearances which are so well shown in the plates. As regards the nature of the disease, it may seem probable that the man was the subject of congenital peculiarity of the skin of the parts affected. During the earlier periods of his life the term keratosis, or possibly that of ichthyosis, was applicable. By degrees, under the influence of the continued irritation of standing in the case of the soles of the feet, and the use of tools, &c., in the case of the palms, gradual increase in the hypertrophic conditions took place. Finally, when the influence of senility began to be felt by the tissues, conditions of over-

PLATE LX.

THE SÖMMERRING-BEHREND CASE.

A REMARKABLE DISEASE OF THE HANDS AND FEET.

THIS Plate shows the condition of the feet in Behrend's case, as described in the text. It will be seen that large bossy masses of hypertrophic out-growth are developed on all parts of the sole not actually exposed to pressure. These out-growths form a sort of fringe round the borders of the foot and toes. The growth, as seen in fig. 2, is especially large on the inner side of the great toe. The parts of the sole actually exposed to pressure in standing are, for the most part, comparatively free from change. The under surface of the heel itself is, however, involved. The dorsum of the foot and toes is unaffected, with the exception of that of the great toe.

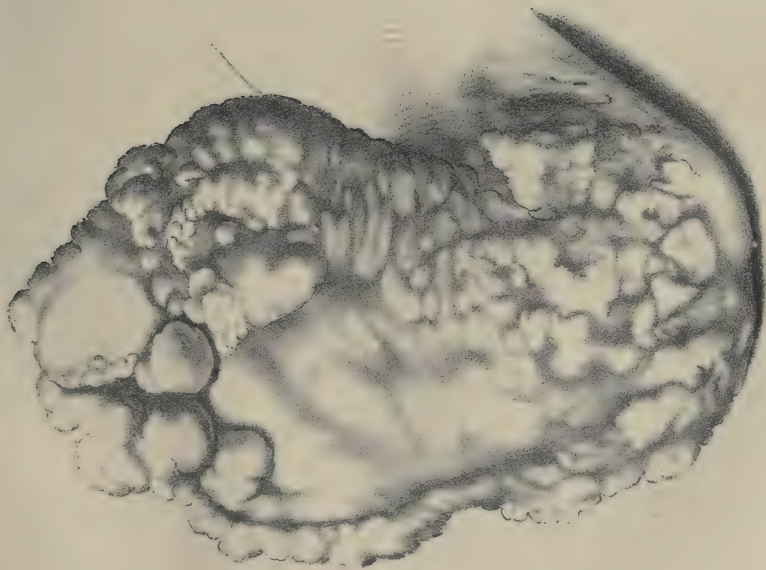


Fig. 1.



Fig. 2.

A remarkable disease of Hands and Feet.

(Copied from *Betrends*.)

West, Newman, lith.

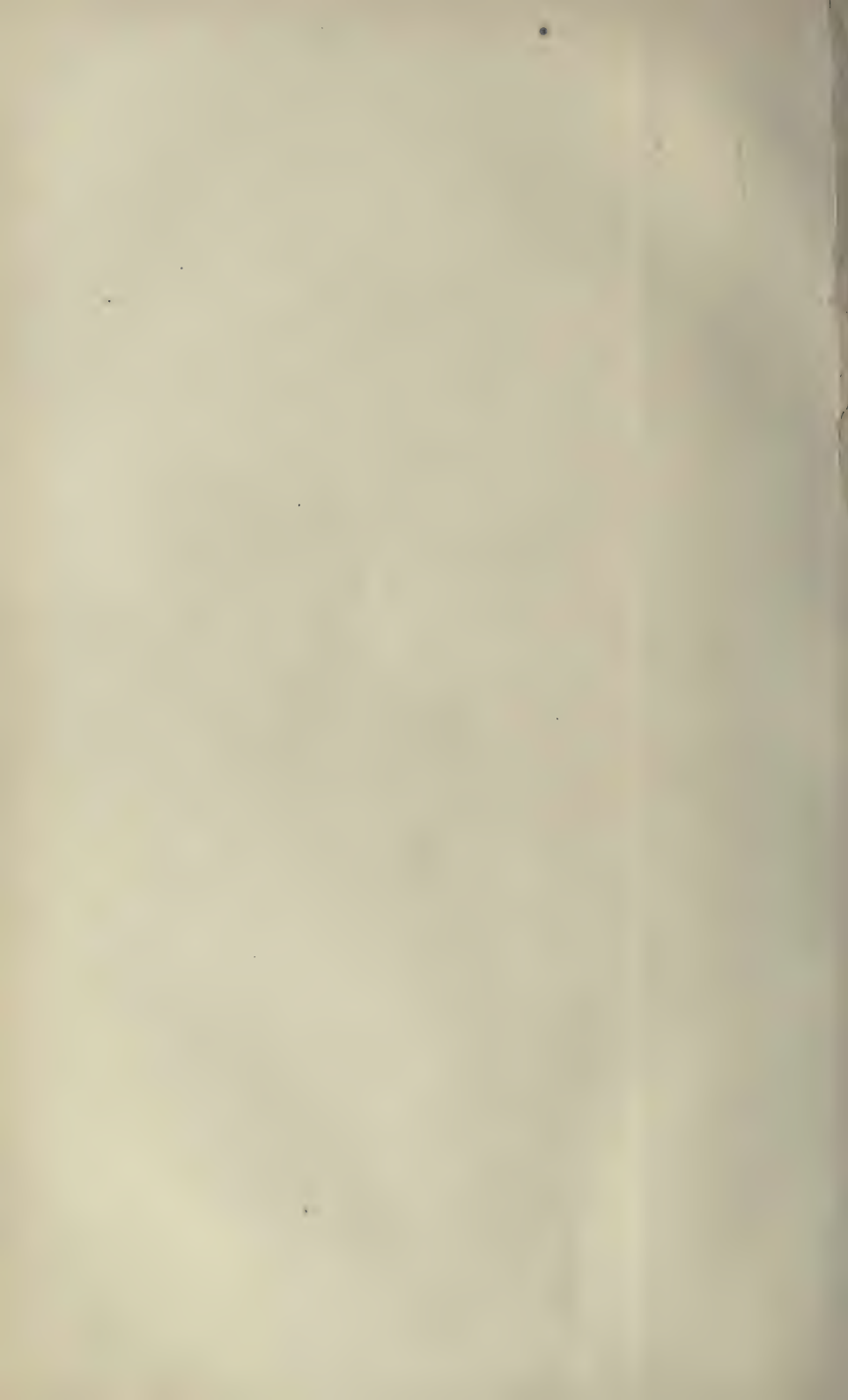


PLATE LXIII.

THE SÖMMERRING-BEHREND CASE.

A REMARKABLE DISEASE OF HANDS AND FEET.

THE hands, from Behrend's case of remarkable disease of the hands and feet. The whole of the palmar aspect of the hands and digits, with but very little exception, was involved in hypertrophic growth, which, in some places, had assumed the form of polypoid, or finger-like excrescences. It will be seen that there are a few nodules on the back of the hand, and that the finger-nails are thickened, fibrous, and over-grown. Plate LX. shows the condition of the soles of the feet from the same patient. They were from a man somewhat past middle life, in whom the disease had been in progress probably from childhood. The sequel of the case is not known. This Plate may be suitably compared with that from Dr. Judson Bury's patient (see Plate LXI.).

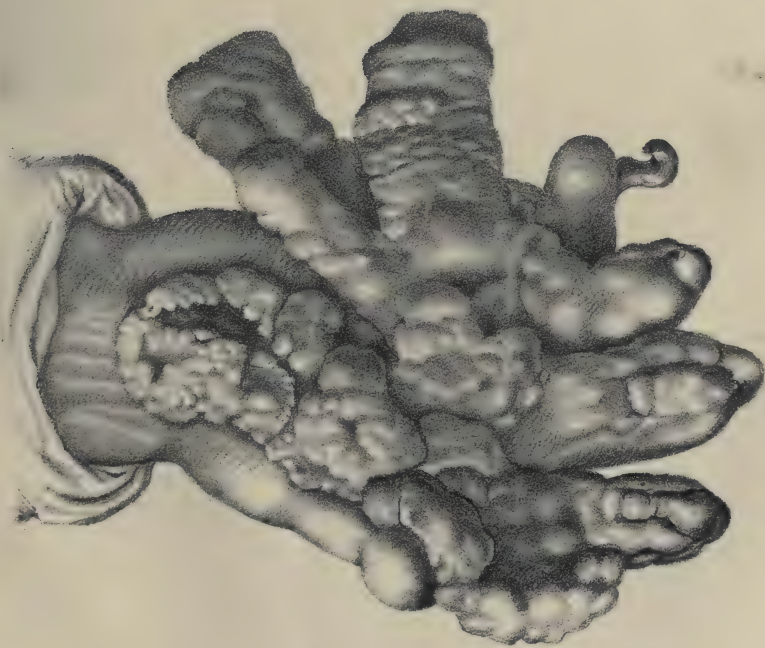


Fig. 1.

Remarkable disease of Hands and Feet.

(Copied from *Behrends*.)



Fig. 2.

West, Newman, lith.



PLATE LXI.

PECULIAR DISEASE OF SKIN OF HANDS, &c.

I HAVE copied this portrait from a drawing given me by Dr. Judson Bury, of Manchester. It is the one to which I have referred in the text, at p. 301; and the case is reported in detail in the 'Illustrated Medical News' for May, 1889. Dr. Judson Bury has been kind enough to supply me with particulars which bring the case up to date. The patient is a child who was twelve years' old when the hands were sketched, and is now fifteen. But very little change in the local conditions has occurred during the last three years. A few of the patches have entirely disappeared, but most of them remain as they were; some of them have become decidedly thicker and more nodular. The girl is in good general health.

Her curious eruption began in July of 1888, and consisted of purple erythematous patches, with considerable thickening, on the palms of the hands, backs of elbows, and fronts of knees. There were the remains of a patch, which had faded, over the left loin. The toes were slightly livid and swollen, and it was stated that the disease had first shown itself on them, and subsequently spread to the knees. On the backs of the digits there were some thickened, almost nodular, patches of a similar character. Thus the fingers presented a lumpy, knotty condition. The patient's family history was good; she was the youngest of twelve, and neither gout nor rheumatism had occurred in her relatives. She had herself, however, had an attack called rheumatic fever, after scarlet fever, at nine years of age.

It is very difficult to speak as to the precise nature of this disease. It certainly very closely resembles, in general features, some cases which I have myself published,* without venturing to give the disease any name; but which were, I have no doubt, of

* 'See 'Illustrations of Clinical Surgery,' Plate VIII., and page 42. Also the 'British Journal of Dermatology,' November, 1888.

PLATE LXI. (*continued*).

the same nature as the disease figured by Hebra as "Sarcoma Melanodes," and which now ranks as one of those which make up the Dermatologist's group of "Sarcoma Cutis." I can scarcely doubt that Dr. Bury's case is of the same nature as my own, but I have never myself seen any approach to it in a young person. The persistence of the condition during three years, and in spite of much treatment, separates it of course very widely from all forms of psoriasis and erythema.

I have special interest in publishing this portrait at the present time, because it seems to me very possible that the disease shown may be an introductory condition to the extraordinary state which occurred in the Sömmerring-Behrend case, published at page 219.



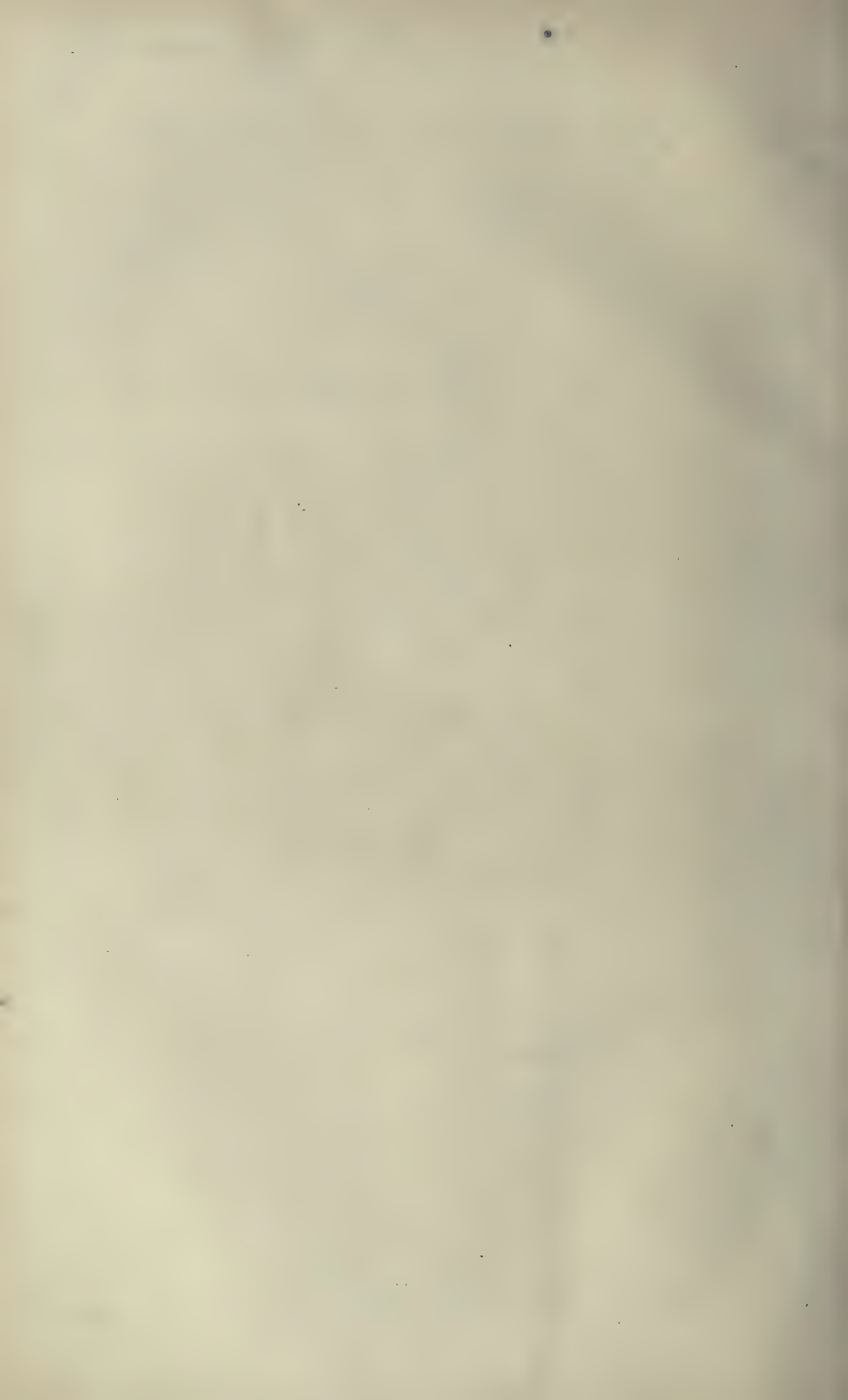
Fig. 1.



Fig. 2.

Remarkable disease of Hands.
(Copied from Dr. Judson Bury.)

West, Newman, lith.



growth ensued which were possibly not far removed from those which histologists of the present day would term Sarcoma. The rapid development of overgrowths during the last three years in parts which had manifested no such tendency during early and middle adult life, demonstrates a tendency towards malignant processes. Unfortunately the sequel of the case is not known. If it were forthcoming, it is, we may suspect, not improbable that it would reveal further developments in this direction.

As illustrative of the form of Keratosis which occasionally occurs in consequence of congenital peculiarity of skin, I may refer to a portrait published in Sir Erasmus Wilson's Atlas, and to one given in the Atlas of Rare Skin Diseases, by Unna and Morris. I have myself seen several examples of it, one of the best of these being a case shown to me not long ago by Dr. Tom Robinson. The portrait published in the *Illustrated Medical News* by Dr. Judson Bury, showing livid or purplish patches in the hands of a girl, may possibly be related to it, but not so closely as those of Keratosis, since the affection was not limited to the palms.

More than one portrait of severe Keratosis of the palms and soles will before long be found in juxtaposition in the Gallery of the Royal College of Surgeons. These represent, I believe, the early stages and slighter forms of what the lithographs here given show in such extreme development.

ON SUBJECTIVE ABERRATIONS OF THE SENSE OF SMELL.

GREAT interest attaches in not a few instances in the observations, as to their own maladies, which medical men have made upon themselves. Many persons are capable of studying their own cases without alarm, and even of making them, under very trying circumstances, topics of interesting conversation. John Hunter's observations concerning his own pulse during a terrible paroxysm of angina are well known. He believed that the circulation had entirely stopped, and set himself deliberately to practice forced respiration in order to restore it. Observing his face in a glass, he records that he was deathly pale. No doubt he was in error in the belief that the heart's action was wholly suspended, but there can be equally little hesitation in believing that during a considerable period it was extremely feeble. On subsequent occasions it is recorded that he entirely lost memory, or at any rate was for a time quite unable to express himself, and believed that he had forgotten everything. The most important lesion which was demonstrated after death was advanced calcification of the coronary arteries. Although there was some disease of the mitral valve, his heart was smaller than usual. Of one distinguished physician—I forget whether it was Haller or Albinus—it is recorded that he studied his own symptoms on his death-bed with the greatest equanimity, and it is asserted, though perhaps it may be doubted, that he counted his pulse to its last perceptible stroke, and quietly remarked to his friend, "It has ceased to beat." Our medical biographies contain a good deal of information as to the maladies from which medical men have themselves suffered, and they would, I think, for those who have zeal and leisure for such matters, be well worth collecting. In a profession like our own, memory requires every kind of collateral aid which can possibly be

given to it. Although narratives of the kind referred to may possibly have attached to them a certain flavour of personal gossip, yet they ought not on that account to be wholly disdained. Many of our case narratives are, it must be admitted, sufficiently dull, and we can scarcely afford to despise any element which gives them interest.

The above remarks have been suggested by the accidental discovery, in the biography of one of Hunter's pupils, of the description of a very peculiar symptom in connection with subjective aberrations of the sense of smell. Before quoting it I will, however, briefly record a case which has caused me to take special interest in this topic. I have at present under care a gentleman who suffers from the recurrence during very short periods of most abominable odours. The symptom may occur at any time of the day, or even occasionally during the night. It may affect him sometimes even during meals. He turns deathly pale, feels faint, and as if he were going to die; then in the course of half a minute a sensation of coldness follows, attended by a most horrible stench. The perception of the latter is so strong that he says it is with the utmost difficulty that he can bring himself to credit the assertions of others that they do not perceive the smell also. This symptom has now persisted for several months. For a month or two at one time he was quite rid of it, and it then returned. He never falls or loses consciousness, and the whole thing does not last more than a minute. He has suffered from syphilis, and is now the subject of complicated symptoms indicative of cerebral disease. Of these, persisting vertical hemianopsia is one of the chief.

The symptom which I have just described has, I believe, received but little attention from neurological writers, and I therefore venture to quote the following narrative respecting it as it occurred in the case of Mr. Cruikshank, the celebrated anatomist. It is taken from Mr. Leigh Thomas's "Hunterian Oration" of 1827.

"The immediate cause of his (Mr. Cruikshank's) death was apoplexy, which he had always foretold would terminate his existence. He was led to prognosticate this event from the circumstance, that whenever he stooped forwards, or, in short,

when from any cause the free return of the blood from the head was interrupted, he was conscious of a peculiar thrilling sensation in the superior surface of the left hemisphere of the brain ; and at this point, it was found, upon examination after death, the mischief had actually taken place. This portion of the brain had the appearance of having been torn ; and the effusion of blood in the surrounding parts was very considerable. There were no other marks of disease within the cranium, excepting a deposit of osseous matter adhering to the falciform process of the dura mater.

“He had also laboured under many other symptoms denoting cerebral disturbance, and as these bore so strong a resemblance to a similar case in a near relation of his own, I am induced to enumerate a few of the most important, and to elucidate the subject, as far as the evidence of two cases will admit ; and which were repeatedly and most carefully investigated.

“As friends they were almost in the daily habit of communicating with each other, and their similar distressing sensations were, as may be imagined, the frequent topic of conversation. They were both men of lively imagination and quick parts ; their habits of life had been so far similar that the mind had been actively employed in both, though in very different situations.

“They were each subject to an entire loss of memory ; which occasionally occurred in the midst of the most animated conversation, as well as when the mind was in a state of quietude. This suspension of intellect was merely transient, and its restoration was equally sudden.

“The sense of smelling was also very obtuse ; commonly the strongest volatiles would scarcely affect the organ, yet whenever any circumstance occurred to excite painful emotions in the mind, they were liable to be assailed with, and suffered the most poignant distress from, the sensible expression of odours, which they invariably described as horribly offensive. Indeed, the pallid face and hurried state of the whole system very clearly denoted the intensity of their sufferings. They were subject to frequent and violent fits of sneezing, and Mr. Cruikshank often remarked that the organ of smell must have

numerous unknown nerves in its composition to explain the complexity of its feelings.

A very short time only intervened between the decease of these relatives; similar in death as in the precursory symptoms. Mr. Cruikshank was the survivor, and investigated with careful and deep attention the state of parts within the cranium. Here blood was found effused to a considerable extent in the left hemisphere, and a bony deposit was attached to the anterior portion of the falciform process.*

"The resemblance in each case was very remarkable; but in neither did the most careful examination detect the slightest alteration in the natural and healthy appearance of the structure of the olfactory nerve."

I have quoted the above *literatim* from Mr. Thomas's narrative. I am not aware that any further details can be obtained. We should like to know whether Mr. Cruikshank and his cousin had had syphilis. It is well known that surgeons are especially liable to be infected in accidental ways. Hunter had himself so suffered. The symptoms bear a very close resemblance to those which I have recorded in my own patient, in whom they are undoubtedly connected with cerebral syphilis. The history of the sudden attacks is suggestive of relationship to the epileptic seizure. If no one has already a better name for the occurrence of sudden epileptoid attacks marked by subjective kakosmia, extreme pallor of face, and sense of impending death, I would venture to suggest that they may be conveniently known as "Cruikshank's Malady."

The perception (subjective) of a bad smell as the antecedent of certain epileptic attacks has received special attention from Dr. Hughlings Jackson, and is now well recognized. The cases to which I refer are, however, of a quite different nature, and are not followed by any kind of convulsions.†

* See Specimen 3,849 in the Collège Museum.

† A case of Epilepsy preceded by Smell-warning, by Dr. Hughlings Jackson and Dr. Beevor, will be found in a recent number of "Brain" (October, 1889).

A VISIT TO EDINBURGH.

(Concluded from page 205.)

I SPENT an hour very agreeably and profitably in looking over a considerable collection of drawings in the possession of Dr. Byrom Bramwell. These illustrated a variety of subjects, but chiefly the appearances of disease as presented in the living patient. As in the case of Mr. Allandale's pathological specimens, I could not help a feeling of regret that objects of so much value should be retained in private hands. Dr. Bramwell may very probably publish a collection from his portfolios. This, however, will not fully answer the end to be desired. Every one of his drawings ought to be mounted, and with a full history attached exhibited in a gallery where all who wished could consult them at leisure. It is to be hoped that in connection with the University Museum a gallery of pictorial illustration will sometime be formed; and that when this is realized Dr. Bramwell will present his collection to it. In one feature his drawings had an advantage over most collections which I have seen; I allude to the fulness of the notes which accompanied them. Not a few very valuable pictorial illustrations, both published and otherwise, have lost three-fourths of their value by the meagreness of the details respecting the cases which they illustrate.

I will not attempt to describe in detail the subjects of Dr. Bramwell's collection. He was kind enough to allow me to bring away as a memento several photographs which interested me very much. One of these is the portrait of a child, the subject of ophthalmoplegia externa. It shows well the

drooping eyelids, divergent eyeballs, and general sleepiness of expression. A companion portrait taken a few months later shows the face of the same child with the lids well up, the eyes well directed, and an expression of vivacity in very striking contrast with that of the first. I have never myself seen ophthalmoplegia externa in so young a child, nor have I ever witnessed so perfect a recovery. I know of very few in which it has been developed in connection with inherited syphilis. The evidence as regards the latter taint was imperfect, but yet to my mind conclusive. There was no history of previous symptoms either in the parent or child, nor did the child's physiognomy show anything suspicious. The cure, however, took place under the iodide of potassium, and a periosteal enlargement of one of the fingers, which had been present, entirely disappeared during the treatment. It was therefore, I think, no doubt one of the not very infrequent cases described at p. 289 of the present number, in which children inherit a taint of syphilis, but display no infantile symptoms whatever. They are precisely those in which also the parental history is most often wanting.

Dr. Bramwell also gave me another photograph, and was good enough to show me the patient himself, in which a very peculiar group of nerve symptoms had occurred, such as one would have been inclined to attribute to syphilitic neuritis. There was, however, after the most careful inquiry, nothing to be made out in corroboration of such a suspicion. The photograph shows well a hollow in the temple caused by atrophy of the temporal muscle after a febrile illness. The patient had regained his health, but without recovery of this muscle, and he still had defective innervation of his tongue and cheek.

Amongst the improvements and developments which are in progress in connection with the Royal Infirmary is the erection of a new operating theatre for the Professor of Surgery, Mr. Chiene. It is to be fitted with every modern convenience in reference both to the teaching of students and the practice of antiseptic surgery. I was also very glad to see the foundations laid for a small new wing, which is to contain wards for skin diseases. These will be under the

care of Dr. Allan Jamieson, who at present holds the position of extra-physician for skin diseases to the infirmary, and has under his care a large out-patient department. The addition of wards will be of the utmost advantage for the teaching of this important speciality; and it is satisfactory to observe that dermatology is taking its proper place in the curriculum of the Edinburgh University. There is as yet, I believe, no collection of drawings or models which is accessible to the students or general public, but it is to be hoped that this want will be supplied before long. Dr. Jamieson possesses a private collection of drawings which is well arranged and described, and which would constitute an excellent nucleus for a collection, when suitable galleries for the display of such objects are provided. For myself I may admit that I regard such galleries as essential to the successful education of the profession in this branch of medicine; and trust that the time is coming when they will be accessible to the students of all our large medical schools.

I attended Dr. Allan Jamieson's out-patient clinic, and was shown several interesting cases, amongst others one of pityriasis rubra, or universal exfoliative dermatitis. The patient was a man under middle age, who had enjoyed good health until attacked by this terrible skin affection. He still, indeed, ailed nothing excepting from the inconvenience and distress which the skin disease caused him. It appeared not unlikely that it might disable him for the rest of his life. Surely it is matter for reflection for those surgeons of high dignity who regard all that relates to skin diseases with a feeling akin to contempt, to remember that after all they probably disable for the pursuits of life a far larger number than are incapacitated either by aneurisms or by stone in the bladder.

I have yet a few sentences to add to the notes already published in reference to the contents of the University Museum. Dr. Alexis Thomson showed me a number of interesting specimens which have recently been added to the collection, illustrating modern knowledge as to tuberculosis as it affects bones and joints. Some of these were from cases of pulpy degeneration of synovial membrane,

the typical characteristic of "white swelling." They became of value because accompanied by microscopic proof of the presence of tubercle and tubercular bacilli. Some of these specimens have been described with good pictorial illustrations in a paper by Dr. Thomson, printed in the second volume of the Laboratory Reports of the Royal College of Physicians of Edinburgh. When will the Royal College of Physicians, London, publish its laboratory reports? In former years it used to issue an annual volume of select papers, but it is so long ago that the fact that it ever did has been almost forgotten.

Amongst the curiosities I was shown a specimen of the bone of the penis of a walrus, in the middle of which was evidence of a united fracture. I was told it was the second specimen illustrating this accident which was known. The union was good, and with but little overlapping.

Some very beautiful examples of recently prepared injected specimens were shown me, and also some drawings and models which had been obtained by first injecting, then freezing, and then making sections. By this means the precise relations of abscesses, tubercular deposits, and new growths to the surrounding parts and to the blood-vessels had been remarkably well preserved.

The practice of making injections of pathological specimens has perhaps been too much neglected of recent years in our London museums.

I was shown also a good specimen of an infant's skull affected by syphilitic periostitis, and exhibiting "Parrot's bosses" in a very well marked manner.

The last specimen to which I shall refer is one which I have already mentioned, and which has been quite recently added to the collection through the zeal of Dr. Alexis Thomson. I was favoured with an opportunity for its private inspection at home before my visit to Edinburgh; and on account of its great rarity, I shall perhaps be excused if I introduce here a detailed description of it. Excellent photographs of it may now be inspected in the Gallery of the College of Surgeons (London).

These photographs represent a skull which affords a most

remarkable example of unilateral overgrowth. All the changes are restricted to the left half of the skull, and lower jaw. Only a few definite exostoses are present, the changes for the most part consisting of diffuse thickening, and overgrowth of the bones concerned. Thus, looked at from the front, the left half might be taken as belonging to a much larger head than the right. The upper alveolus comes much lower down, and the frontal and parietal bones stand higher than on the opposite side. At the same time the bones of the right side look thick and coarse, and lumpy; though without any definite exostoses. This lumpy thickening is especially marked in the malar bone, and in the frontal just over the orbit. In proof of the increased size, it may be stated that the measurement from the lowest part of the orbit to the alveolus is on the left side $2\frac{1}{3}$ inches, and on the right only $1\frac{1}{2}$ inch. The malar bone on the left side from the orbit to the lower part of its zygomatic process is two inches, being double that of the opposite side. Neither the orbit nor the nasal fossæ are in any way encroached upon, nor are the thin bones of the roof and inner walls of the former, nor any part of the ethmoid or turbinated bones in the least thickened. The nasal bones are not involved in thickening, but are curiously twisted, owing to the general enlargement of the left side of the face. The occipital bone and the posterior part of the parietal bone show but little evidence of thickening, nor is there much in the mastoid process or the adjacent part of the temporal, though a certain amount of enlargement is here present. Thus the chief evidences of enlargement are in the superior maxilla, the malar, the frontal, and the left half of the sphenoid. By the projection inwards of its inner wall and outwards of its outer one, the capacity of the frontal sinus on the left side is very much increased. It measures three-quarters of an inch across, an inch-and-a-half in length, and would contain a pigeon's egg. All the foramina on the left side are very much larger than those on the right; thus the supra-orbital notch on the left is by a bridge of bone converted into a foramen, of a size which would easily contain a crow-quill, whilst the infra-orbital would take a goose-quill.

At the base of skull the distance from middle of		
basilar to root of zygoma is on right side	...	2½
" " " left	...	3¼
From top of mastoid to most prominent part of		
lower margin of orbit (compasses) on right side		3¾
" " " " " left		4½

The space between the pterygoid plates is on the left side much wider than that on the right.

There is a very large socket for the canine tooth on left side, much larger in all dimensions than that on the right.

The skull is that of an aged woman. On the left side the socket for the canine tooth only is present, and on the right those for the canine and one molar. The others are on both sides quite obliterated.

The hinder part of the alveolus on the left side is very thick, and the thickness increases as we pass backwards. The portion of alveolus between the canine socket and the symphysis of the maxillæ is not materially thickened. As a rule the tendency seems to be for all the hypertrophies to increase in proportion to distance from middle line. There is a series of very large pacchionian pits in the inner table, just to left of middle line, in the parietal bone.

The foramen magnum is almost symmetrical.

The left hamular process is prolonged into a spur, and another long stout spur springs from the base of the external pterygoid plate. The anterior clinoid process is prolonged backwards as a thick spur.

The foramen ovale is twice as large on the left side as the right, but the general overgrowth of the left bones draws it a little to that side. Posterior to a line drawn across the middle of the foramen magnum there are no evidences of overgrowth, excepting some increase in thickness of bone. The surface for articulation of condyle of lower jaw is twice as large on the left as on the right side, and occupies the base of the zygoma, extending it outwards.

The capacity of the skull on the left side looks much greater than on the right, but this is probably due to the way in which the skull has been cut. The occipital bone is not in

the least increased in thickness on the left side. The condyles for the atlas are of the same dimensions on both sides.

The hollow for the jugular vein on the left side is very large and deep, and easily receives the end of the little finger.

The hollow for the lateral sinus is far greater on the left side than the right. Probably the patient always slept on the heavy half of the skull (Mr. Hilton's theory).

The lower jaw is much elongated on its left side, and its condyle is twice the size of that on the right. In this respect it almost exactly resembles a lower jaw figured in Adam's work of "Rheumatic Arthritis," Plate I., fig. 1.

I have had special interest in thus describing this specimen because it is nearly the counterpart of one in my own possession, which was, I believe, unique until this was obtained. They are of course the *post-mortem* relics of a condition which is extremely rare—unilateral hypertrophy of the face. They are of very great physiological interest as illustrating unsymmetrical lesions of nutrition and growth, which can scarcely be explained on any other hypothesis than that they are due to nerve influence. The tendency is, I believe, usually shown in very early life. At what period it is arrested we do not know. The patient both in Dr. Thomson's case and my own lived to be old. The cases must be kept quite apart from the far more common ones of hemiatrophy of the face consequent upon morphœa in early life. With these they have nothing in common beyond the fact that in both the lesions are probably localized by the fifth nerve.

I have not myself ever seen in the living subject a good example of one-sided hypertrophy of the face. I find recorded by Schiek* an example of it, which he observed in a girl of nine. It had begun at the age of two, and implicated the soft parts as well as the bones.

Sir George Humphry has also published† a case of unilateral hypertrophy of the gums and side of face, including the ear, palate and tonsil.

In the Gallery of our College of Surgeons, in juxtaposition with photographs of Dr. Thomson's specimen and my own,

* "Berliner Klin. Woch." No. 45, 1883.

† "Annals of Surgery," vol. iii. p. 1.

UNILATERAL EXOSTOSES OF SKULL.

I have placed an engraving from Heuss' Atlas, showing exostoses from the skull bones on one side only, but in this instance there is not much proof of general overgrowth of bones. In conclusion, I may briefly mention another specimen taken possibly from a similar case. It is that of an unsymmetrical lower jaw, which was presented to the Royal College of Surgeons by Mr. McCarthy, of the London Hospital. It is 2205 in the Catalogue. In this case one half of the jaw is apparently much too large, and the other at the same time somewhat too small. The increase is not so much in thickness as in length, and the over-length of the right side gives to the bone a peculiarly twisted appearance. There are no nodosities or anything of the nature of an exostosis upon it. The overgrowth of the right half ends at the chin, but not in a very abrupt manner. The coronoid process of the right side, although somewhat larger than the opposite one, is not involved in the overgrowth, and is somewhat smaller than that of a healthy bone. The articular process on the contrary is much enlarged and misshapen, and might have been supposed to be affected with chronic rheumatic arthritis. Its neck is long and twisted, and shows signs of an oblique united fracture.

The history of this specimen throws no light upon the cause of the curious deformity. Mr. McCarthy tells me that it was obtained from an artilleryman who had become quite deaf, in connection possibly with his occupation, and who died in the London Hospital from an aneurism. He was about fifty years of age. The one sidedness of his face was very noticeable during his life, and led to the removal of the specimen. No alterations were observed in the skull or in his limbs.

CASES OF PARALYSIS OF THE DELTOID IN CONNECTION WITH SYPHILIS.

CASE I.—*Paralysis of the Deltoid Muscles in the fourth year of Syphilis—Complete on one side and partial on the other—Recovery under treatment.*

In the following case we have, I think, in all probability an example of syphilitic neuritis affecting the circumflex nerve. It finds, perhaps, its best parallel in the cases which we occasionally see of syphilitic paralysis of the fifth. Syphilitic neuritis of single nerve trunks, if we except those of the muscles of the eye, are very infrequent. Thus the portio dura is attacked with extreme rarity, and the nerves supplying the extremities with yet greater infrequency. A very remarkable feature in the following case is the fact that the condition was bilateral. The deltoid muscle was completely paralyzed on one side and its anterior half on the other. In both, the affected muscle became atrophied, and the skin over it was partially anæsthetic. Under specific treatment long continued the atrophied muscle became re-developed, and regained its full power. These facts are in exact parallel with what we observe in paralysis of the fifth. I published many years ago a series of cases, some of which proved that it was possible for the temporal muscle, after having undergone complete loss of substance, and having been in the condition of atrophy for some months, to be completely restored under the use of iodide of potassium. These cases will be found in the Moorfields Hospital reports. I have never until the present instance seen a case in which I ventured to diagnose syphilitic neuritis of the circumflex nerves. On searching my note-books, however, I

have found a mention of two cases which were not improbably of this nature. These will be appended to the present narrative.

On January 28, 1890, a gentleman, aged 29, consulted me on account of inability to raise his right arm. I found on stripping him that he could not use his right deltoid in the least, and that the muscle was so wasted that its presence could not be detected by the hand; the head of the humerus and other bony points appearing to be immediately subcutaneous. The skin over the whole deltoid region was partially anæsthetic, and, as he expressed it, the shoulder felt "dead numb." In the other arm, the anterior half of the muscle was in a similar condition, whilst the rest was plump and active. The history of the case was that Mr. W—— had been treated for syphilis in September, 1886. He had, as he said, "a terrible throat," and was under the continuous treatment of a highly distinguished surgeon for six months. After that, on account of repeated recurrences of eruption, he often took mercury for longer or shorter periods, on and off. During 1888 he was most of the year in the tropics, and bore the heat well. Having returned in May of 1890, he had a few spots and rings on the arms and body which were accounted syphilitic, and for which mercury was again prescribed. In October of the same year, about four years after the original disease, he began to suffer from a variable and not very severe pain in his shoulders. In November this pain had increased, and he was obliged to keep the house. It was called rheumatism. During December the pain was very severe indeed, so that he could not sleep, and on four or five occasions its severity was such that he was obliged to call up his medical attendant in the middle of the night to inject morphia. The pain was somewhat on both sides, but much worse on the right than the left. He described it as having been most intense just at the back of the armpit, where it was, he said, just as if some one were using an oyster knife. The skin over the right shoulder became numb, and the pain gradually abated; but he found that he was quite unable to lift the arm, and in this condition he came to me as above stated in the end of January. He was at this date

in tolerably good health, and he had no other signs of syphilis. I believe that he had, during his month's confinement to bed, taken iodide of potassium in moderate doses. The surgeon who had attended him, informed me afterwards that there had never been any particular increase in temperature. The treatment had been by the salicylate of soda with, during a part of the time, the iodide of potassium. I prescribed for Mr. W—, on January 28th, mercurial pills, in conjunction with iodide of potassium in mixture. A month later the left arm was better, but the right not much; and the doses of iodide were increased. On March 28th I had still to record that the right deltoid was not improving, and that on the left side the anterior half of the muscle was still wasted. He had a syphilitic urticaria over his abdomen, and a few iodide spots on his face. The medicines were still continued, and shortly after this note both muscles began to improve. The improvement, however, was only slow, and in the autumn of the year he went to Aix-le-Bains, where he thought that he obtained much benefit from massage. After this he continued the treatment in smaller doses, and in January of the present year—twelve months from the time that I first saw him—he was quite recovered. He had then taken no medicine for two months or more; his deltoids were again of good size, and he could lift his arm well. His right was perhaps the more plump of the two. He was at this latter date anxious to marry, and I assured him that he might do so with safety.

It is a noticeable fact in the above narrative that the improvement did not commence until after the specific treatment had been used for a considerable time, and that after it had once begun it continued steadily, although specifics had been suspended. I have noticed the same protracted recoveries in other cases of syphilitic neuritis, and do not think that they in any way invalidate the diagnosis.

It seems worth while just to add a few words as to the peculiar form of disability which paralysis of the anterior half of the deltoid entails. As stated, on the left side the posterior half of the muscle was never in the least affected; and during the progress of recovery of the muscle the

posterior half on the right side was that which was first restored. Whilst in this condition he was able, with a certain amount of manœuvring, to hold his arm at right angles to his chest. It was necessary that it should be in complete supination, and if he attempted to pronate ever so little his arm dropped down to his side at once. Thus he could not venture to hand a plate at table, as he was sure to drop it in attempting certain movements. He could always put his hand behind him easily, and did not need assistance in dressing. All the other muscles of the upper extremity, excepting the supraspinatus on the right side, appeared to be in good condition; but I have to confess, in reference to this point, that I did not test them by galvanism.

When a nerve lesion is symmetrical, the suspicion of central disease of course occurs; and I should not like to express any positive opinion respecting the present case as to the precise position in which the neuritis began. The skin over the deltoids receives its nerve supply from other sources as well as from the circumflex, and we could not therefore expect that complete anæsthesia of any part should result from destruction of its trunk. The condition complained of by Mr. W——, was rather a “dead numbness” of the skin, which also was not absolutely without sensation. He said that the skin of his right shoulder always felt cold to his hand. Abolition of the functions of both motion and sensation in the tract supplied by a mixed nerve is of course an almost conclusive indication of disease in the course of its trunk. The occurrence of severe pain such as that which Mr. W—— experienced in the early part of the case, is also, I should suppose, indicative of peripheral neuritis rather than of central disease. On the other hand, we must remember that there are certain clinical facts which appear to indicate that the nuclei of origin of the circumflex nerves are in some way peculiarly liable to be implicated in disease. No muscle, perhaps, affords us so many examples of isolated paralysis as the deltoid. I have recorded in a former number of the ARCHIVES an example of its symmetrical and complete loss in connection with infantile paralysis.

CASE II.—*Paralysis of anterior part of Deltoid from Peripheral Neuritis in the course of Ataxy after Syphilis.*

It would appear that the innervation of the anterior part of the deltoid is in a definite manner distinct from that of the rest of the muscle, for I have seen a second example of paralysis of this part only. In this second case the patient was a man of thirty-five, who had suffered from syphilis eight years previously, and in whom symptoms of ataxy were threatening. He had no patellar reflex, was quite blind in one eye, and complained of weakness in micturition.

The symptoms produced by this defect are peculiar. There is a sense of difficulty in lifting the arm from the side, and it is accomplished only by an effort and with muscular manœuvring. When once up, however, the arm can be kept there. It is difficult, or impossible, to bring the hand to the back of the head. Efforts at lifting the arm cause pain about the lower angle of the scapula and in the latissimus dorsi. The wasting of this part of the muscle could easily be felt. The rest of its substance, as in the previous case, appears to be in good nutrition.

CASE III.—*Unexplained paralysis of the Deltoid Muscle in a man who was the subject of Syphilis.*

I once saw (almost by accident, the patient not being under my care) a remarkable case of paralysis of the deltoid. The subject was a healthy man a little past middle age, who had some subcutaneous knots and lumps in the mammary regions which were believed to be due to syphilis. When he was stripped I noticed that there was wasting of his left deltoid, so that the outline of the head of the bone was easily seen, and appeared to hang low. On asking him what had happened to his shoulder, he denied all knowledge of accident, and seemed to think there was nothing the matter with it. He could use his shoulder with certainly very remarkable facility, and lift it up almost as quickly and almost as high as the other. In lifting it, however, he clearly did most of the movement by the scapula. The wasted deltoid and fascia could be felt, but

on careful examination by several observers we could not make out that there was any action in any part of its fibres. I forgot to test sensation over the muscle. The muscle on the opposite side was in perfect condition, and the man had no other nervous symptoms.

I have made some little search amongst such works on the nervous system as are accessible to me without being able to find any cases similar to the preceding. I have indeed failed to find any detailed references to paralysis of the deltoid, alone, in connection with nerve causes. I do not know that the question of the possibility of paralysis of one lateral half of the muscle, alone, has ever been previously entertained, nor am I acquainted with any anatomical facts which would explain it. The only reference to this part of the subject which I have found is a statement of Duchenne, that in a case in which there was partial recovery of the deltoid after infantile paralysis, the anterior part recovered while the posterior remained atrophic. In this instance the atrophy of the deltoid was of four years' standing, the patient being a boy of seven and a half years. The other muscles of the upper limb were implicated as well as the deltoid. The anatomical facts in reference to the innervation and structure of the deltoid are so well known as scarcely to need recapitulation. It is supplied by the circumflex nerve, which comes off in common with the musculo-spiral, together with some other branches, from the posterior cord of the brachial plexus; and it supplies the teres minor as well as the deltoid, giving twigs also to other adjacent muscles. The deltoid muscle is of coarse structure, and its bundles are to some extent separated by bands of fibrous tissue. One of these does, in a sort of indistinct way, divide the muscle into two lateral halves. Although the muscle as a whole is concerned in elevating the upper limb, its clavicular and scapular portions work independently, and in mutual opposition, throwing the humerus forwards or backwards. This latter fact has no doubt an important meaning in reference to the occurrence of paralysis of one half of the muscle.

THE TREATMENT OF LUPUS BY KOCH'S FLUID.

IN the last number of my ARCHIVES I briefly referred to two cases which had been under my care, and in which only negative results had been obtained from Koch's injection. Since then I have had (chiefly in connection with the post-graduate lectures at the Examination Hall) large opportunities for estimating the value of this method. Many cases were sent to these lectures for class demonstration, which had been treated by different surgeons. Amongst those to whom I was most indebted for opportunities of examining their results were Dr. Heron, Mr. Watson Cheyne, Mr. Waren Tay, Dr. Abraham, Mr. C. Macnamara, Dr. Hitchens, and many others. If I were now to sum up the result of my experience I fear it would be on the whole an unfavourable record. Not a few of the cases appeared to be little, if at all, improved. In some, I am bound to say, the results were, after long perseverance, excellent. Yet even of the best I cannot assert that I have seen a single one in which the disease was cured. The best results seemed to be obtained in cases in which there had been extensive inflammation with ulceration, &c., and without much of the true lupus growth. In these the attacks of inflammation induced by the injection appear to have had a very similar effect to that which we not infrequently witness after attacks of erysipelas. In the cases which most nearly approached to cures there always remained little islands of the brown apple-jelly deposit ready on the slightest provocation to set up new disease. In cases of what may be called quiet lupus, in which there is only the brown apple-jelly growth, without inflammation, I much doubt whether this treatment is of any avail.

DISEASES OF THE SKIN.

No. XLIII.—*On the Non-existence of Prurigo as a substantive disease.*

IN my "Lectures on Certain Rare Skin Diseases" I have devoted considerable space to the consideration of the different forms of "Prurigo." Amongst other points I felt bound to express the opinion that the disease for which Hebra endeavoured to claim that name has no real existence. Since then I have, of course, continued to devote considerable attention to the subject, and may now briefly record my experience by stating that my note-books do not contain the record of a single case which would deserve the name of "Prurigo" as that of a substantive malady, or which would fit with the statements made by the distinguished Vienna Professor respecting it. In saying this I am well aware that I differ from many of my *confrères* for whose judgment I have the sincerest regard, and who are in the habit of occasionally making the diagnosis of "Hebra's Prurigo." I observe, however, with some satisfaction, that this term is falling into disuse, and that it is beginning to be generally acknowledged that if there is such a malady, it is met with in Vienna only. My inclination is not in the least towards controversy, and if the matter were one merely of verbal distinctions and of differences of custom in the use of words, I would most gladly let it rest. It is, however, one respecting which clinical accuracy is of very considerable importance, and on that plea I again recur to it.

No. XLIV.—*On Hereditary Irritability of Skin as the basis of what is known as Hebra's Prurigo.*

If I were to try to state clearly what, so far as I understand the matter, is the difference between the views of Hebra as

regards prurigo and those which I have myself ventured to entertain, it is mainly this. We both believe in a peculiarity of skin, born with the individual, which renders him especially liable to have it become irritable. Hebra holds that this peculiarity sometimes rises to such a height that without the intervention of any exciting cause, whether blood change, nerve disturbance, or external irritant, the skin may, as it were spontaneously, produce little itching papules, and further, that the tendency to produce these will begin in infancy and last till old age, with but little amelioration, either from change of climate or mode of life, or from drugs. My own view of the facts is rather that those born with pruriginous liabilities require, usually, some exciting cause or the development of their miseries. I hold also that the exciting causes may vary very much in nature, and that in connexion with each some modification in the result is witnessed. Thus the exanthemata, heat, cold, clothing, parasites, may each and all in turn, with many other agencies, be the effective causes of prurigo; the type of the evoked malady varying somewhat with each.

Thus in one sense the difference between us is but slight, for we are both obliged to fall back upon the hypothesis of a fundamental peculiarity in the individual as the remote cause of prurigo. For practical purposes, however, the difference is really considerable, for since under my theory much is attributed to exciting causes, many of which are susceptible of removal, much is to be hoped from careful attention in this direction. With Hebra, I quite admit that the peculiarity of skin which gives liability to pruriginous affections lasts through life and is in that sense incurable. But on the other hand, I think that such persistence is rarely made apparent unless the surroundings of the patient are exceptionally unfavourable; and further, I believe that the special mode of manifestation usually varies a good deal at different periods of life.

In the list of cases which I have given in a table appended to Lecture VI,* there are many children who were uncured at the date of the last note. Most of these cases would

* See "Clinical Lectures," vol. i. page 90.

probably be classed by a disciple of the Vienna School as the early stage of the life-long form. But the question is, Will they remain uncured? and to this I have already given such reply as is possible. It is mainly this, that whilst we see scores of children with "infantile prurigo," few indeed are the adults in whom the condition has persisted. In the table to which I refer I have purposely retained the names of the children, thinking it possible that this may perhaps lead in the future to the identification of the patient by myself or others, and that thus important evidence as to the final result may be obtained. We want—in this subject as in so many others—complete cases, not mere fragments.*

No. XLV.—*Pruriginous Eczema much aggravated by scratching, and persisting through life.*

The case of a gentleman who consulted me in September, 1876, may serve to illustrate what I have been saying; but in truth such illustrations are very plentiful. Mr. W—— was aged 60, tall and rather pale. His father suffered from gout, but I saw no reason to connect this fact with the son's malady. When Mr. W—— first came he had a copious pustular eczema on his legs and thighs, with a slight diffuse eczematous state of his arms also. He said that he had been liable to it all his life, and he had in former years been under the treatment of the late Mr. Startin. On one occasion Mr. Startin relieved him quickly and very definitely by an ointment containing the nitric oxide and bisulphate of mercury.† Subsequently, however, this application failed to do any material good. On asking for detail as to his statement that he had had it all his life, he told me that

* For similar reasons I have in these ARCHIVES, whenever it could be done without risk of revealing anything which might be inconvenient or disagreeable, retained the patient's name. A rare example of disease often passes under the care of various observers, and its identification may not infrequently lead to very useful results. In all other cases I have carefully endeavoured to prevent identification.

† I subjoin Mr. Startin's prescription:—R. Hydr. Nitric-oxyd. gr. vj. ; Hydr. Bisulph. gr. iv. ; Cerat. Cere ʒj. It was to be applied twice a day. With this was an aperient, chalybeate mixture.

in boyhood and through middle life he had always had an itching, irritable skin. It was, however, never attended by any spots, and was often well for months together. The relapses, so far as he could remember, were not produced by changes in weather, nor did they occur specially in winter or summer. The first appearance of eruption occurred as a few scattered spots on his legs, which becoming aggravated by scratching about five years ago, passed into "sores." He described the itching as having been "fearful," and was well aware that he had aggravated the condition by scratching.

The conditions were symmetrical, both legs and both arms being affected. The face had never suffered. A brother and a sister had both suffered through life from irritable skin, but neither of them had ever had any breaking out. He considered himself a very bilious subject, but had never had gout.

I prescribed for him in September, 1876, a weak tar wash and a tar and mercury ointment, but he persevered with them through the winter and with but little benefit, and came to me again in April, 1877, rather worse than better. The eruption on the legs was now a suppurating eczema in irregular patches, with œdema and with scabs. There were many small scars of former ulcerations. On his arms were very large ill-defined areas of eczema in its more ordinary condition and without pustules or scabs. The skin was everywhere extremely pruriginous, and he was worn out by want of rest.

Although Mr. W—— remained for some years more or less under my observation, and with, of course, much temporary relief, yet I must admit that nothing approaching a cure resulted. One hindrance was his incurable addiction to scratching.

If I am asked why I refuse to recognize in such a case as this an example of prurigo of Hebra's type—an incurable disease lasting from childhood to old age—my reply is that we really have only an aggravated example of pruriginous eczema. To give it a new name is to dissociate it from its natural congeners. For one such case lasting through life, we have thousands almost exactly like it which have been cured in

childhood. Had this patient had more self-control and been more persevering in treatment, he too would have got well. The misfortune was that he had an irritable skin easily made to itch, and that when it did itch he would scratch. To say that he was the subject from the beginning of an incurable and lifelong malady is to divert the attention from the true chain of causation, and lead to remissness in the use of treatment.

No. XLVI.—*A Pruriginous Skin—Eruption of some years' standing aggravated by scratching — Keratosis of the palms from arsenic.*

Dr. S——, of G——, sent me a somewhat peculiar case, of which the following are the particulars. In writing to me, Dr. S—— stated that the eruption had been regarded as syphilitic, and that the patient had made his life miserable by dwelling upon this suspicion, and believing that the remains of the poison in his blood disqualified him from marriage, &c. It had even been feared that he would commit suicide. He had been under many physicians and some specialists, and by some the disease had been pronounced syphilis, and by others, as confidently, a different diagnosis had been given. The patient brought with him not only Dr. S——'s letter, but a very detailed account written by himself. This must be briefly summarized by stating that in 1883 he had a sore, from which nothing of the nature of secondary symptoms resulted. In the spring of 1884 he began to be troubled with itching on the knees and elbows, which was followed by soreness and itching on the scrotum and thighs. He was told that this was due to the hot climates in which he had lived. During the last three years he had taken mercury and arsenic internally during long periods, and in large doses.

It was a papular and erythematous eruption evidently much scratched. It was arranged symmetrically, and occurred chiefly on the borders of the axillæ, on the buttocks, legs, and abdomen. Everywhere it had left minute white scars.

It affected the face slightly, also the scalp and the front surfaces of the arms. There was none in the fronts of wrists, and none between the fingers.

At first sight of the eruption on the sides of armpits and buttocks, I felt sure that it was an uncured scabies of very long duration, but I could find no burrows, and the history negated this view.

The palms showed a condition of diffuse keratosis with little hard corns, which he was in the habit of picking out with his nails. I thought that this was probably due to arsenic, and found on referring to his prescriptions that he had taken arsenic for years. "Nearly every doctor whom I have consulted gave me arsenic in some form."

Before this special eruption he had been liable to common acne, and used to perspire freely. Mercury had never done him any good. He had often been kept awake by the itching. "You might as well tell the sun to stand still as tell me not to scratch." I mentioned the term "Shoemaker's buttocks" to him, and he at once added, "Well, do you know when I sit in a tramcar the movement makes the buttocks itch till I can scarcely sit still."

As regards the keratosis of his hands, he said that his finger-ends were at one time numb,—a remark which confirms the suspicion that their present condition has been induced by arsenic (see ARCHIVES, vol. ii. page 196). I formed the clear opinion that the eruption was not syphilitic, and that in all probability he had never had syphilis. It was a form of lichenoid eczema with extreme pruriginous tendency. The susceptibility to local influences, friction of clothes, scratching, irritation from his seat, &c., had been most marked. The patient lacked self-control, and had scratched severely. The state of his palms was, I believe, the result of the drug which had been used for his cure,—that is, it was arsenical keratosis. Confirmatory of this suggestion was the fact that he appeared to have suffered at one time from arsenical numbness.

NO. XLVII.—“*Hebra's Prurigo*” in early stage—
Pruriginous General Eczema in a young child,
as yet uncured.

The case of a little girl named Violet C—— is of much interest in reference to this subject. It was a very good example of the first period of what many authorities call “Hebra's Prurigo.” In essential features, however, I must contend that it was eczema. As to whether it will or will not be a life-long disease will depend upon the care and attention that is given to the treatment. There is no question that it will prove a great trial to the perseverance of the mother. When I first saw the child she was a little more than two years old, of rather dark complexion, and in good general health. She had been continuously under treatment since the age of four months. Her body and limbs were covered with a scratched lichenoid eruption, which was especially severe across the loins. On account of this eruption the child had never been vaccinated. It was believed that she had never had chicken-pox. The eruption affected the hands as well as the forearms. It did not affect the face or scalp to any great extent when I saw it, but I was told that it had begun on the face. Now as to its eczematous character we may note that it began at the age, and on the part, at which infantile eczema is most common. Further, it affected the lips and mouth, the popliteal spaces and fronts of elbows, and on all these parts it was characteristic eczema. It was exceedingly pruriginous, the child was constantly tearing the skin, and no doubt its characters had been much modified by scratching. There was no history of skin diseases in the family. The mother told me that both she and the child had exceedingly irritable skins, and if attacked by fleas, suffered terribly. The child had at one time been nearly cured by a three weeks' residence at the sea-side; and at another time had been much better at Reigate. It did not appear that this was in reference to the water used in washing, since they always used rainwater at home. The child had been brought up after the first six weeks by hand. I advised that it should abstain from milk, and as much as possible from sugar; should take

green vegetables and potatoes freely. The prescription consisted of a tar lotion to be used as a bath and as a wash ; and of medicine containing the bicarbonate of potash and bromide of sodium.

No. XLVIII.—*Pruriginous Eczema in an infant, lasting, uncured, into adult life.*

A case which was shown to me by my friend Dr. P—— well illustrated the state into which this child will eventually pass, unless we succeed in curing it. Dr. P——'s patient was a young man of 22 or 23, and was shown me as a good example of Hebra's Prurigo. He was covered from head to foot by a pruriginous eczema. It was worst in the popliteal spaces, and on the fronts of the upper limbs. The history was that it had begun in infancy on the scalp, and as far as we could ascertain, had then exhibited all the peculiarities of infantile eczema.

No. XLIX.—*Pruriginous Eczema in an adult—Much scratching.*

I have rarely seen a case which, in its external features, more closely resembled what is called Hebra's prurigo than did that of Mr. A——. He was an intelligent Scotchman, and head keeper to Lord D——, and was sent up from a northern county for a state of skin which had proved intractable under a great variety of medication. He was a man of strong will, and not over equable temper ; and had been a most resolute scratcher. On entering my room he proceeded at once to strip himself in order to show his distressing condition. Although well tanned by weather on his face, his skin under his clothes was far darker, owing to the pigmentation caused in part perhaps by remedies, but chiefly by incessant scratching. On many parts the skin was thickened and indurated, this being especially the case on his legs, arms, and in the cleft of the nates. On his abdomen and buttocks there were a number of hard chronic pustules, dusky in colour, and varying in size from an acne spot to a small

furuncle. On his buttock was one positive boil; but for the most part these furunculoid indurations ended with very slight suppuration, and without any core. Mr. A—— said that nothing he had tried materially alleviated the itching, and that often he did not sleep till daylight, and for months together he did not get more than three hours' sleep. Under these conditions he had somewhat lost flesh, but was, in the main, still a vigorous man. Some other points about his skin require to be mentioned; on the fronts of his wrists there were groups of little papules about as big as pins' heads, which were arranged in transverse lines, and which were becoming polished on their tops, reminding one of lichen ruber. On his elbow tips were large oval scaly patches, exactly like psoriasis. In the upper part of the cleft of the nates the skin was thick, hard, dry, and scaly, again resembling a condition not unfrequently met with in this part in psoriasis. On other parts the morbid changes were diffused, and a general condition of dryness and scaliness with pustules, papules, and little fissures made up the *tout ensemble*. The face and neck were almost free.

Having thus sketched the features of the disease, and shown how large a part the pruriginous element took in it, let us now examine as to the history. Mr. A—— was not aware that there was any special tendency to skin diseases in his family; he had nine children, and none of them had suffered from eczema. He assured me that up to the age of 20 his skin had never been irritable. About that time he had a severe attack of itch, which was prevalent in the village. He recovered from it, but had frequently remarked to his wife that his skin had never been right since; by which he seemed to mean that it had been discoloured, and more liable to itch. In early life he had suffered from acne on his shoulders, which had left many scars, and had at various times been subject to boils. The severely pruriginous state I have described had not fully developed itself until eighteen months before I saw him, and it then began as a sort of dry eczema on the leg. From this leg it spread up the thigh, then affected the other leg, and then the whole body. It had been getting steadily worse and worse. In former years Mr. A—— had drunk

spirits in excess ; but he had always, as a gamekeeper, lived a healthy out-of-door life. Although he had been told that his liver had been enlarged, and had once suffered, eight years ago, from pleurisy, there was no reason to think that he had materially damaged his tissues.

If now we proceed to analyze the case, as regards its various elements of causation, we may probably in the first place recognize a proclivity to acne and boils—a furunculoid predisposition—which had existed through life. Next we have a severe and prolonged attack of general scabies, which left the skin hyper-æsthetic and irritable.

Inattention to the proper means of cure and resolute and persistent scratching must rank as the next factor ; and lastly, but of great importance, the infective qualities of all eczema. The patch of eczema which occurred in the leg probably infected the rest of the skin. Thus we recognize a chain of partnership causation, producing complicated phenomena. This is, I would submit, a very different thing from giving the disease a definite and specialized name. That the case although presenting features of similarity yet did not conform to the type of Hebra's Prurigo, is obvious. It had not begun in infancy, nor even in early life.

I may briefly remark that I have never yet seen in advanced life an example of a severely pruriginous skin in which the history went back to infancy.

No. L.—*Recurring inflammation of the hands in a healthy boy—Vesicular and bullous eruption, with tendency to form pus—Usual duration of attacks a fortnight—Present attack more severe—Extension to trunk—No benefit under arsenic, and cure under antimony.*

When we succeed in the formation of a natural classification of diseases, a separate family must be formed of those which tend to get well of themselves and after an interval to recur. Whether we shall feel justified in classing all such as

in essence "catarrhal" * may be open to doubt, but most clearly they differ from all others.

It is obvious that in such cases as the following, the proneness to recurrence without obvious cause is by far their most important clinical feature, and with it we may place the tendency to spontaneous, or almost spontaneous, disappearance. These features separate them widely from all forms of eczema, and also from all common types of pemphigus. On the other hand, they ally them closely with the conditions which I have described under the name of cheiro-pompholyx. The present case indeed only differs from typical examples of the latter malady in the great excess of inflammation and the tendency of the inflammatory products to become purulent. These features may have had something to do with the early age of the patient: for all the cases of cheiro-pompholyx which I have as yet seen have occurred in adults. The fact that the boy was always noticed to be out of health a few days before the eruption appeared is quite in accordance with what is noticed in cheiro-pompholyx.

There are other forms of dermatitis which are liable to periodic recurrence such as noted in this case. The New Sydenham Society's Atlas contains a beautiful portrait of a case of "erythema marginatum" in a young and healthy boy, in whom the history was that it recurred periodically and got well almost spontaneously. It was a severe eruption, and was attended and preceded by considerable disturbance of health. In that case we found that arsenic not only rapidly cured the disease, but definitely prevented its recurrence. For years afterwards the boy's mother used to keep her arsenic medicine in the house, and if the boy became fretful or languid it was at once had recourse to. Under this plan no severe attacks were ever developed, although there were often slight threatenings. I thought it not at all improbable that arsenic might in a like manner control the attacks of inflammation of the hands in the case which is about to be described. In this expectation, however, I was disappointed.

The subject of my present case was a boy aged about eight

* For explanation of the meaning which I give to the term "catarrhal," see ARCHIVES, vol. i. pp. 307-8.

years, who was brought to me in May last, when I took the following notes :—

The present attack is the worst that he has ever had. He never before had any spots on his face. He has often had slight or abortive attacks. The last severe one was in the autumn. Season has not appeared to exercise any influence. The attacks usually occur two or three times a year. The first definite attack of “blisters on the hands” was at Shanklin when he was a year and six months old.

Before an attack occurs he is usually languid, and complains of his legs aching. No local irritation has ever been observed as a cause. He is sometimes bilious, but in the main has good health. He is a very free sweater. He plays about with other boys in hot weather, and does not suffer from his hands excepting that he gets “heat spots” on them. His father was liable to eczema when a child, but not badly.

The conditions presented by the hands when this boy came under my care on May 1st are tolerably well shown in a sketch which was executed for me by Mr. Burgess. It shows the fingers swollen and excoriated, and the backs of the hands covered with small bullæ, most of which contained opaque greenish pus. On the wrists and lower parts of forearms there were some undeveloped erythematous patches with more or less of tendency to bullous effusion. The epidermis was loosened in several parts of the palm. On the day before the sketch was taken I had prescribed arsenic, and the disease was already apparently on the decline. A week later I was able to make the following note :—

Master B—— (May 7, 1890) ; his hands are rapidly getting well. The bullæ on the backs of hands have almost all dried up, and the general inflammation is much less. There is still a little sore at one corner of his mouth. He is reported to be better in himself, but still easily tired. His appetite is returning. The tongue is cleaning. It has been covered with a thick creamy fur.

My next note records a relapse and an extension of the disease.

May 16th.—He has been taking arsenic and bark, and using a boracic ointment. He has not regained appetite, and is, on

the whole, worse. The eruption has spread up his arms, upon his face, and has appeared on his knees. He has frequent micturition, and sleeps badly.

The eruption spreads as a pustular and vesicating lichenoid eczema. His hands are still excoriated all over. On his face it is pruriginous. He has had much headache.

At this date, as the eruption, although better on the parts on which it began, was still extending, I decided to change the treatment. The arsenic was abandoned, and tartarised antimony substituted in doses of one-sixteenth of a grain three times a day. A week later I was much pleased with his improvement.

May 22nd.—Under the antimonial mixture he is much better, and has a very good appetite. Hands much better, and face, although thickly crusted, less inflamed. Many spots in front of right knee, but all less inflamed. His feet, which were swollen, but without actual eczema, are better. The eruption is practically dead. He had felt much out of sorts, but under the antimony feels quite well.

After this last note I believe he soon got well.

No. LI.—*A case in which Leucoderma has become almost universal, and the scalp hair has become white.*

Mrs. J—— (formerly Miss R——) is an example of leucodermic changes having spread over the whole surface. They began at the age of 8 by white patches on the hands, neck, and face. Now, at the age of 28, she is blanched over the entire surface, excepting some patches on her body. (These I did not inspect.) Her hair is almost wholly white. Here and there, however, are some dark tufts, especially on the occiput. Her eyebrows and eyelashes have not blanched, but are still of a moderately dark-brown colour. The whiteness of her face and neck is very striking. She was originally of a dark complexion, and her mother is very dark. Her hands are quite white. During summer, when exposed, she does not tan at all, but the skin of the neck may become red and even sore. She has rather florid cheeks, but when suffering from

headache she becomes of marble whiteness over the whole face.

In girlhood I attended her for ringworm, and it is believed that it is on the parts then affected that the dark hairs now grow.

Mrs. J—— has been under my observation, more or less, most of her life. I believe that the leucodermic changes are still advancing on the body, but her face, neck, and hands have been in their present condition for some years past.

No. LII.—*Coloured Perspiration.*

There is a curious symptom which I have not seen noticed by other writers, which consists in coloured perspiration from the axillæ. Sometimes it is coincident with coloured secretion from the sebaceous glands—indeed I am not sure it is not a fact that the colour is always derived from sebaceous secretion, and not from the sweat itself; probably the sweat dissolves the sebum. In one case, in a gouty gentleman of about fifty-five years of age, little beads of an orange colour used to form on the hairs of his axillæ, and would adhere closely to them. When he perspired much—and he used to break into perspiration very easily—the moisture stained his linen. He was liable also to excoriate between his toes from perspiration. In another case a surgeon, aged fifty-four, again the subject of gout, was very much annoyed in warm weather by perspiration in his arm-pits, which stained his linen red. There was no proof in this case of any excess of sebaceous secretion.

No. LIII.—*A very peculiar form of Clustered Comedones—Large groups placed symmetrically on the thighs.*

A very curious case of comedones in groups, or local seborrhœa, was brought under my notice in the person of an elderly lady, Mrs. C——. It should be stated in the first place that Mrs. C—— had been through life the subject of a dry skin; she said that she had never been able to perspire, and that in early life when heated her skin would flush and

burn intolerably. As years had advanced she had suffered less inconvenience from this, but the skin still remained not only free from tendency to sweat, but also without any liability to become greasy. She had for years been accustomed to sponge herself with a weak solution of glycerine in rose-water. This she said had suited her better than any other application, and had the effect of preventing the skin feeling dry and harsh. Her skin was indeed, without being actually scaly, in a slight condition of xerodermia or ichthyosis minima.

Quite recently Mrs. C—— had suffered from a severe hepatic illness (probably gall-stone). The condition for which she consulted me was what she called patches of eczema on her thighs. These had troubled her for about a year. I found that the patches were not in the least eczematous, but that they consisted of groups of plugged sebaceous follicles. There were two patches placed quite symmetrically on the outer part of each thigh, a little below the great trochanter. Each was about as large as an outspread hand, and shaded off at its margins gradually into healthy skin. The patches consisted of a great number of hardened and polished plugs of sebum. Some of these were not larger than pins' heads, but many were as big as small shots. The largest were in the middle of the patches, and towards the margins the conditions gradually diminished until the gland orifices could only just be detected as brownish dots. There was not the least inflammation of the intervening skin, but the spots were so closely placed that they were almost confluent; in fact in some instances two or three seemed to have coalesced. In order to convince Mrs. C—— that they could be removed, I made her lie down on the couch, and proceeded with an acne scoop to extract the plugs. After about a quarter of an hour's diligent work I had removed probably about a hundred, and the skin was left covered with a number of little holes which were quite dry. The plugs did not go any depth into the skin, and in some instances, specially near the middle of the patch, they were almost globular. Towards its margins they were longer, and more like "the grub" from a common acne comedone. The longest, however, was not more than one-

eighth of an inch. They were all absolutely dry, almost like bees-wax. The process seemed to be one in which the plugs, while they increased in size, were gradually extruded from the follicles. I have no doubt that they would in the end have dropped out, although even in their dryest condition they still adhered very firmly.

From the exact symmetry of the condition, and from the entire absence of spots on other parts of the skin, it did not seem probable that any source of parasitic contagion would be found. On all other parts, as already explained, the sebaceous glands were remarkably free from tendency to enlargement. I examined the little plugs after removal, found them exceedingly hard, but splitting under pressure into shiny scales. They dissolved in benzolene with great difficulty. I did not succeed in detecting any parasite either animal or vegetable.

No. LIV.—*Two cases illustrating Psoriasis Eczema of the hands.*

I wish to contrast two cases of disease of the skin of the hand which are at present under my care, in order to illustrate, among other things, some of the differences which are sometimes observed in reference to difference of age. In the first case a girl of 17 is the subject of a sort of mixed psoriasis-eczema of the hands. It affects chiefly the backs of her hands, being specially severe around the roots of the nails and in the cleft between the thumb and forefinger. Its arrangement and characters are shown in a sketch which I possess. Although it is now for the most part a scaly eruption, and unattended by any moist exudation, the history given by the girl's mother seems to show that it was in the beginning an intertrigo-eczema, for in early childhood it affected the popliteal spaces and the axillæ. These parts are now quite well, and the hands and feet alone are affected. On the latter it has now persisted for many years. It is to be specially noted that the palmar aspects of both hands and feet are perfectly sound. The pulps of the fingers are smooth and soft, but around the roots of all

the nails there is a border of inflamed skin with scale-crust. The nails themselves are pitted and furrowed on their surfaces, but not thickened. In the senile case about to be mentioned the reverse of these conditions is observed. The palms suffer and the backs of the hands are free. The finger-pulps are dry and cracked, but the nails wholly escape. In the case of the girl some little approach to what I have named sycosis unguium is seen, although it is by no means a well-marked example of that malady.

The senile patient is a lady named N——. She is sixty-seven years of age, stout, and although she does not know of any gouty history in her family, she has herself suffered from an inflammation of the great toe joint which she describes as very much like gout. Her skin disease consists in a diffused dry inflammation with cracking and peeling of the whole palms, and especially of the finger-ends. She has had it for two years, and it is slowly advancing on the fronts of the wrists. The soles of the feet are affected symmetrically just under the insteps. Here again the patches are of the same character, the skin becomes dry and peeling, with cracks. The affected parts burn and tingle, and the condition of her finger-pulps is such that she can scarcely use her hands. The nails are very slightly affected, and only where the inflammation extends from the finger pulp under their free borders. There is no pitting of their surfaces as in the other case. It will be seen that there is in this instance a certain amount of evidence in favour of the gouty origin of the malady. The urine deposits a considerable quantity of uric acid, and the patient has suffered from attacks which were probably mild gout. There is no history of skin disease in early life. Her case may I think be taken as a fairly typical one of a form of psoriasis palmaris met with now and then as a distinctly senile disease, and which is very rarely seen in early life.

No. LV.—*Two cases of Chronic Skin Disease (unnamed)—A Desquamative Dermatitis persisting without any failure of health for many years.*

I have at present under care two patients in whom certain

skin phenomena of long persistence are almost exactly alike, and, so far as my acquaintance with nosology goes, very difficult to name. Both my patients are men, and both apparently in robust health, and neither of them would care anything about his skin disease were it not that it is very conspicuous and entirely prevents him from bathing in public. In one case the patient has the additional source of disquietude and anxiety in that he believes his affection to be syphilitic; but in the other this suspicion is not present. It may be most convenient to take my second case first. Mr. Q—— is an Irish lawyer, aged 30, whom I have seen several times during the last fifteen months. The skin disease began twelve years ago, that is at the age of eighteen, and at that time he had never had any venereal affection. Since then he has had an "excoriation," but it was not followed by any indications of constitutional disease. His skin disease at present consists in large, erythematous, slightly desquamative areas on his limbs and trunk. They are so abundant on his thighs and legs that almost the whole surface is covered. On the sides of his abdomen, and on the fronts of his arms, there are a few large but quite discrete patches, there being none on his back, or front of chest, &c. The whole of his scalp is involved, but is only very slightly affected, the condition being one of diffuse pityriasis. Mr. Q——, who is an intelligent and highly educated man, tells me that the affection began on the front of one forearm, and that he then considered it an erythema. Two years later, in the summer of 1879, he had a general peeling of the whole surface. At this time, though he did not feel in any way ill, he was "so branny all over" that the scales used to shake off when he undressed, and would collect in his bed. One might suppose that he was then the subject of a pityriasis rubra, but the affection was not a severe one, and disappeared after a few months without any very special treatment. When it went away his eruption lapsed into its present condition, and so it has persisted ever since, being sometimes better and sometimes worse. He has not been able to appreciate any very definite increase from weather, but thinks that it is rather worse in winter. At other times it gives him no material

inconvenience; but in frosty weather he says his thighs are apt "to get aired,"—by which he means, I think, that there is more or less tendency to chapping. Excepting a certain degree of itching of the scalp at night, he has no irritation. He has tried a great deal of treatment and has taken a good deal of arsenic; and has never experienced any material improvement from any drug. It is to be understood that in its present stage the eruption only desquamates slightly. Some of the patches are abruptly defined, but on many parts of his thighs they have coalesced and the condition has become diffused.

If I were to describe the case of Captain S——, I should have to use precisely the same terms which I have employed for Mr. Q——. The same parts are affected and the same appearances have been produced, with these differences, that he has no pityriasis of the scalp, and at present there are some lichen spots over the whole front of his chest. I am describing his eruption as it was on December 31, 1888. It began in 1874, and has never left him completely during the whole of the fourteen years. There is a very doubtful history of remote syphilis; but he is married and has four healthy children, and his eruption does not look like any syphilide with which I am acquainted. I saw him first in May, 1874, and then assured him that it was not syphilis and ordered him only a tar wash. In August, 1874, as the eruption still persisted, I ordered arsenic. In May, 1888, my diagnosis appears to have wavered, for I find that I then ordered him mercury. I may add that in 1876 he saw Mr. Berkeley Hill, who told him that he did not think his eruption was syphilitic. The eruption had in the first instance begun as coffee-stains on his ankles, and had steadily advanced up his legs.

In both these cases the eruption was quite symmetrical. I may ask attention to the fact that in neither has the prolonged use of arsenic done any good. In this point, as in several others, we have a marked difference from common psoriasis.

DISEASES OF THE NERVOUS SYSTEM.

No. XXVIII.—*Complete Deafness, following an injury to the head—Loss of smell and taste.*

But very few cases are on record which may give us help in the prognosis of such as the following. The all-important question for the patient and his friends is, will the total abolition of a special sense, which at present exists, be permanent? Cases of deafness in one ear from fracture of the base of the skull crossing the petrous bone are not uncommon, and in them I fear the condition is usually lasting. The peculiarity of the following case consists in the fact, that probably the bone lesion is symmetrical.

A young gentleman, of about twenty-four, who had been attending a social dinner at one of our metropolitan hotels, in going down the stairs caught his foot in the carpet, and fell. It was not known exactly how he fell, but it was probable that the chief injury was from striking the back of his head on the edge of the stone step. He was found by his friends, who were following almost immediately after him, at the bottom of a short flight of steps, face forwards; but his face was not in the least bruised, whilst a line across his occiput was swollen, and it continued afterwards for some days very tender. It was quite certain that he had not been pitched forward on to his vertex. He was quite unconscious when found, and was in the same condition when Dr. M—— reached him about half an hour later. He was then bleeding from the nose, but not very profusely. There had been no hæmorrhage whatever from either ear. During the next twenty-four hours he gradually regained consciousness, and when that was

attained it was found that he was absolutely deaf. Subsequently it was ascertained that he had lost smell also, and taste to a certain extent. There was no facial paralysis, nor any trouble as regards the bladder or bowels. During the two days immediately following the accident he was extremely thirsty, and insisted on drinking quantities of water, which he always speedily returned by vomiting, and usually with some traces of blood. During this period he was not allowed to take any food by the mouth. During the second day he had two attacks of convulsion, during which, the nurse states, both sides of his face and all his limbs twitched violently. A condition of extreme restlessness characterized the first few days. He liked to bury his face in the pillow, and was never quiet for more than a minute or two at a time. He complained of severe headache.

When I saw Mr. W—, in consultation with Dr. M—, on the fourteenth day, most of the symptoms had passed away. He was sitting in his chair, reading the newspaper, and looking quite well. The distressing fact which remained was that he was still absolutely deaf. It was believed that he had never heard anything whatever since the accident, excepting possibly on one occasion a loud cough, but even this he afterwards denied. I procured a loud-sounding bell, and rang it close to each ear, but he assured us that he heard nothing. He had regained his taste to a considerable extent, and probably his smell also, but not equally. He did not now complain of any headache, and could take food well. He denied that he felt giddy; but he walked with a reeling gait, as if he were so. The chief question of course concerned prognosis; was it likely that he would regain his hearing? Dr. M— and I agreed in the diagnosis, that he had in all probability sustained a fracture of the base of the skull; which, beginning at the occiput, had passed forwards through the petrous portions of both temporals, and had ended in the ethmoids. It was a remarkable fact that the portio dura, on each side, had entirely escaped. In all probability, both internal ears were filled with blood.

Examination of the membranes showed the left drum very much drawn in, with swelling of the meatus near to it; the right showed no very definite change. There was no sign of

perforation in either, and, as already said, there had been no bleeding from either.*

No. XXIX.—*Complete Paraplegia still present six months after a Dislocation of the Spine.*

I saw at St. Thomas's Home, with Dr. Edmunds, a case of much interest in reference to the symptoms of crushing of the spinal cord. The patient, a gentleman of thirty-five, stood six feet two, and had consequently a very long back. In consequence of the slipping of some earth from the top of an old fortification, he had fallen with the earth a height which was subsequently ascertained to be nearly seventy feet. He was stunned for the time, and nothing definite is known as to the precise position in which his body had come to the ground. The conditions about to be described, however, make it almost certain that he was forcibly doubled up with the head between the thighs. As soon as he had regained consciousness it was ascertained that his lower extremities were completely paralyzed, and that he had no sensation below the level of his navel. The accident occurred in Burmah, in June, 1890, and our consultation on his case took place in December of the same year, a few days after his arrival in England.

The indications, when I saw the patient, were quite definitely those of a displacement between the tenth and eleventh dorsal vertebræ. At this position there was an irregularity, the spinous processes of the eleventh and twelfth very decidedly projecting backwards. The displacement was not great, but it was definite, and it could only have been produced, I think, by some crushing of the body of the eleventh. The line of the spinal column was quite straight, as regards lateral displacement; and no material

* I have never demonstrated in the dead-house a circular fracture of the base, which had begun at the occiput. The bleeding from the nose which occurred in this case, and the entire loss of smell, make it probable that the fracture had passed forward into the ethmoids, and on both sides. This, however, is not certain, for the loss of smell may have been due to contusion of the olfactory bulbs. In one case of circular fracture of the base, with absolute deafness, which I proved post-mortem, the lesion was caused by the man having fallen head foremost on to his vertex. See Pathological Society's Transactions.

posterior projection would have been noticed if the patient had been standing up. It was appreciable on manipulation, but scarcely so to the eye. On inquiry as to the history of the symptoms immediately after the accident, I found that there had been retention of urine, which was relieved by the catheter on the second day. The catheter was employed for some days afterwards, and then the bladder recovered some of its tone, and incontinence resulted. There had been from the first incontinence of fæces whenever the bowels were relaxed. I inquired as to priapism, seeing that the injury was just in the position likely to have produced it. Our patient said that he was not aware that it had occurred; but as the parts had been throughout completely devoid of sensation, he did not know much about it. He said that he had suffered much from erotic dreams during a few weeks after the accident. He believed that he had been "off his head and delirious" for some little time, a week or two after the accident; although he had been perfectly conscious in the first instance. There had been large bedsores on his sacrum and heels, but they were now almost cured.

Our consultation (which took place on December 31, 1890, just six months after the accident) chiefly concerned the questions as to prognosis and treatment. Was it likely that the case would end fatally? was it possible that the use of the legs should ever be regained? and lastly, was it desirable that any operation should be performed? Taking the last first, I felt no hesitation in discountenancing the idea of operative interference. The displacement of the vertebræ was not sufficient to make it at all probable that any compression of the cord by the laminae was still existing. Probably the cord had been crushed at the time when the body was most bent, and the bones had been almost completely restored to position when the trunk was straightened. This view was quite in accord with that entertained by Dr. Edmunds previous to our meeting. As regards prognosis in reference to probable prolongation of life, the patient having regained good bodily health and his bedsores being almost healed, we had chiefly to think of the possible consequences of disease of the bladder and kidneys. He

had had cystitis, and was not yet wholly free from it. The bladder, however, was now accustomed to relieve itself, and the use of the catheter was not necessary excepting for washing out. Thus although it was impossible to ignore the danger of secondary disease of the urinary organs, it did not appear to be either immediate or great. With care the patient might live on for years. We next came to the question of the probability of repair, and in order to answer this we carefully examined the history as to improvement and the facts as to his present condition. Although six months had elapsed, it could not be said that there was any return whatever of sensation or motion in the paraplegic parts. He could not accomplish the slightest movement, nor could he feel in the least. The boundary of the loss of sensation was a line curving from behind forwards to a little below the umbilicus.

The only points in which there was any history of improvement were, that he was now free from the pain which he had first experienced; that he had much less of the sensation of girdle tightness; and that his lower limbs did not jump as much as they used to do. Dr. Edmunds had observed, respecting his reflexes, that whilst there was no movement produced by striking his ligamentum patellæ, a response could always be obtained by hitting the shin-bone or the patella itself. The movement produced was, however, not a jerk forwards, but a flexion at the knee by the hamstring muscles. No irritation to the skin or soft parts, on any part of the lower extremities below the knee, evoked the slightest movement. The latter occurred only when the bones were struck. On the thighs, tickling of the skin at once produced slight flexion at the knee. In the earlier periods of the case the patient said that he had been much troubled by jumping of the limbs, but it had been less of late. This entire absence of any return of functions and the completeness of their abolition were very unfavourable symptoms as regards the probability of recovery.

In a case which I mentioned in my presidential address at the Neurological Society, a gentleman who had been eighteen

months confined to his bed, for an injury to the spine attended with great and conspicuous displacement of the bones, recovered so far as to be able to walk about. His permanent inconveniences were incontinence of urine and fæces, with a liability to attacks of cystitis at intervals. He has, however, for some years been engaged in the active pursuits of life, and has even recently married. His case differed, however, from the one given above, in that the injury was to the lumbar spine, and that the paraplegia was never absolute.

No. XXX.—*The influence of Arsenic upon the Nervous System.*

I do not think that there can be any reasonable doubt that arsenic does in a remarkable manner influence the vaso-motor system, and produce alterations in the supply of blood. Thus, it may cure the erythema of lupus erythematosus, but it may cause flushing of the face and eyes, and burning sensations in the hands and feet, which are the equivalents of flushing. The symptom of red eyes and pricking of the conjunctiva as an indication of the influence of arsenic on the system, has long been known. It is an intermittent condition which comes and goes. In some cases there is pricking only with a pale condition of conjunctiva, and a sensation as if sand were in the eye. In many, the eyelids are puffy. In all cases, reading and all use of the eyes is more or less painful, especially by artificial light.

These eye symptoms are by no means the whole of what arsenic may do in disturbing the capillary circulation. It may cause a very marked tendency to flushing of the whole face. The flushings will occur in connection with exciting causes such as usually produce them, as after taking food, or on coming out of the cold air into a warm room. At the same time there may be evidences of disturbance in the extremities, the hands and feet may tingle and burn, and may become very tender. In rare instances little horny warts may form on the fingers, or the epidermis in the palms may first thicken in patches and subsequently break up.

These remarks are illustrated by the following case:—

Miss H—— left off the arsenic last summer, but took it again last Christmas, in doses of seven minims three times a day regularly. These doses have been continued for three full months. She now complains much that her eyes prick, and that she is liable to most painful flushings of the face. These flushings occur chiefly after meals. Her sister says that her face becomes almost purple.

She has had chilblains all through the winter. These she often had before, but not quite so badly. Her hands and feet feel tender, and swell. On both hands and feet a number of little corns or horny warts have formed. These are on the fingers, not in the palms. She is liable occasionally to “pins and needles” in the limbs. Reading by artificial light is painful. Her appetite is good, and she feels strong and well. Menstruation regular but painful.

Her lupus patches have got almost well, that in the nose having, however, left a keloid scar.

No. XXXI. — *On the form of Paralysis which attends Spina-bifida in cases in which the patients survive.*

Two examples of survival with spina-bifida have come under my observation recently. One is a child named Young, whom I have seen at times from infancy; the other a girl of sixteen, brought to me for the first time by Mr. Fitzroy Benham. They are so closely similar that it may be convenient to contrast them.

In Mr. Young's child the feet have gradually turned in until now there is an almost complete condition of varus. She has recently taught herself to walk, but treads wholly on the outer border of the foot. Her legs are exceedingly thin, and all the muscles weak, but it is very difficult to tell which sets are most affected. She walks with great trouble and much uncertainty. Her mother says that she is much improved as regards retaining her urine and feces, but still has incontinence of both at times.

Her progress would encourage the belief that the nerves affected by spina-bifida may to a certain extent regain their function. The same lesson is taught by the next case also, for in it the patient now but rarely suffers from incontinence of urine in the daytime, and at first asserted that she never happened accidents with her bowels.

The second case was brought to me by Mr. Fitzroy Benham from the Queen's Jubilee Hospital, and was of yet greater interest, for the patient could walk well. She was a well-grown girl of sixteen. The spina-bifida, as in the preceding case, was in the lower sacral region, and not quite in the middle line. In both it lay rather to the left. It was large, and freely fluctuating, almost as big as an infant's head. It was reported to have got larger of late, but it had caused no inconvenience excepting from its bulk. The girl had very slender but shapely limbs, and could walk well. I could not discover any tendency to talipes. It was admitted that there was a liability to incontinence of urine, but it was asserted that there was no trouble with the bowels. On examination with the finger, however, I found that the anal sphincter was quite relaxed; in fact I could not appreciate any action whatever, and easily passed two fingers side by side. The bowel was full of hard, dry feces, the condition of which was the explanation of their not escaping.

Mr. Benham had on three occasions during the last three months tapped the tumour, drawing off many ounces of serum. Our consultation was as to whether any radical operation was required. I found Mr. Benham averse to Morton's injection plan, alleging that he had repeatedly known ill results and even death from it. I opposed any other kind of operation. My argument was that in addition to the danger, it was impossible that such an operation as excision of the sac could do any good. It could not possibly benefit the sphincter-paralysis, and it was very possible that it might damage the nerves still more, and make the sphincters weaker, or even injure the lower extremities. I urged that in these cases there was usually no aggressive tendency. The tumours did not increase, and the innervation of the

regions involved improved rather than otherwise. The permanent inconvenience is the bulk of the tumour, and it is not worth encountering much risk merely to get rid of this.

I have on former occasions published not a few cases of spina-bifida. In several which I have seen patients have lived to adult age with considerable tumours, and no paralysis whatever. In one such, a woman had a family of children. In others, the feet escaped, but the sphincters were defective. In no case have I known the sphincters escape if there was any defect in the feet. I am not myself responsible for the death of any patient excepting quite young infants, who were treated by paracentesis only; but I am cognizant of several in patients of more advanced years, who might have lived if let alone.

DOCTRINAL PATHOLOGY.

(Continued from page 212.)

I HAVE elsewhere adverted to three remarkable features which are not unfrequently observed in Melanosis. The first of these is that the primary growth may never develop at all; the second, that the gland growth often attains a very large size; and the third that there is frequently a remarkable tendency to multiplicity of reproduction, amounting to almost universal dissemination throughout the body. In cases in which the original tumour remains small, and in which there has been no reproduction in the glands, the ordinary laws of population-increase may probably be called in to explain this last peculiarity. The Greeks colonized the whole of the Mediterranean, but nowhere developed any large city. The Romans, sparing in colonization, grew into an enormous home state. It is clear that the laws of population would prevent any nation from accomplishing both these ends at the same time; you cannot both scatter and keep. So in new growths, the amount of specialized material which the body can afford is restricted within certain limits. If the primary growth increases quickly, it does not at the same time give material for the infection of other parts; and if a gland-mass grows largely, it probably to some extent prevents the tendency to multiple manifestations elsewhere.

The prevalence of Diphtheria in the wards of several of our London Hospitals during the last few months has occasioned great anxiety. I have observed with much satisfaction that nothing has been made out as to the existence of unwholesome conditions in the wards of the Institutions which have suffered. Rather the general conclusion seems to have been that it spread by contagion only. This is in accordance with what I have contended for long. The evidence in sup-

port of the contagiousness of diphtheria appears to my mind most conclusive, and further, it so well explains the facts that it is almost difficult to find a place for the supposition that the disease is ever produced by defective drainage. If stagnant and drain-polluted water in close proximity with dwelling-houses could produce diphtheria, Rotterdam, Amsterdam, nay, even the Hague itself, ought to be depopulated. There are many houses, and even towns, in England also which ought to suffer severely. The disease, however, does not occur with any special virulence under such conditions, but breaks out in a fatal epidemic in some village or town of which the health conditions are, like the Hospital wards of St. Bartholomew's, unexceptionable. Many years ago I was compelled to pay attention to the laws of spreading of diphtheria in consequence of its occurrence at Haslemere and its neighbourhood, and amongst my own family and relatives. It then passed from house to house without the slightest regard to sanitary conditions, and appeared to be as purely a matter of contagion as an epidemic of measles.

It becomes exceedingly difficult, when once the possible range of the effects of contagion is realized, to feel confident that such a disease as Diphtheria has any other cause. Untrained minds, we well know, accept evidence easily as to the efficiency, as a cause, of any influence which is obviously present. Miss Nightingale, in spite of her intelligence and her frequent intercourse with medical men, held firmly that she had often known small-pox originate from bad Hospital arrangements. The anti-vaccinators often express the same creed, and almost invariably contend that variola can be prevented from spreading by attention to sanitary laws of the same kind as is successful against typhoid fever. Whilst, however, I venture to contend that when diphtheritic inflammations become epidemic they do so in virtue of their contagiousness, I would by no means place this malady in the category of the exanthemata and contend that it cannot be originated *de novo*. On the contrary, the evidence seems to me to support the belief that it is a form of catarrhal inflammation beginning, like all true catarrhs, in cold-catching, and developing its own

material of contagion just as the commoner forms of catarrh undoubtedly do.*

The conditions under which Plague spreads by contagion are worthy of our special notice. It is believed on excellent evidence that little or no danger is encountered in a short interview with a plague-patient. It is only those who remain some considerable time in the atmosphere of a plague-inhabited house who are in risk of receiving it. Physicians rarely take it from their patients, whilst, when under the old and barbarous rules for prevention of spreading all the members of an infected house were compelled to remain within its doors, it was but seldom that any escaped. A physician of extensive experience in the disease, who became himself the subject of it, is reported to have assured his friends, "You may come and see me and talk to me without risk, only you must not stay long." In this feature of requiring prolonged exposure we have a strong contrast with small-pox, measles, and scarlet fever, any one of which may be taken by a passing whiff of a patient's breath. It suggests the probability that the bacillus of plague is easily killed by exposure to ordinary air, and thrives only in the moist, effluvium-laden atmosphere of rooms. All the facts respecting it favour this belief, for it spreads where houses are crowded, and is thus said to be a "disease of the miserable." In large, well-ventilated houses it appears to have but little power, and the knowledge of this fact constitutes one of the principal sources of security as regards any future epidemic in England.

It seems certain that the virus, or fomites, of plague can be carried about by a person who is not himself suffering from it. The same is notoriously the case with that of erysipelas. Very possibly it is so with all the exanthemata. In the case of erysipelas it is well known that the surgeon's hands or coat-cuffs, &c., are a source of great danger to operation cases and to his midwifery patients. Puerperal fever is probably in a large majority of instances produced in this way.

* See ARCHIVES, Vol. i. page 307.

The lectures recently given by Mr. Watson Cheyne as Hunterian Professor at the Royal College of Surgeons were of much interest in demonstration of the easy artificial production in the lower animals of tuberculous disease of bones and joints. Following the practice of injecting human tuberculous matter into the nutrient arteries of bones, he proved that all the phenomena witnessed in spontaneous tuberculosis in man could be produced. By this plan of course all injury to the bone itself is avoided. Nor is any special proclivity in the animal necessary for the success of these experiments. The supposed immunity of the goat from tubercle upon which an absurd proposal for treatment has recently been based, is effectually disposed of by the fact that other experimenters as well as Cheyne have habitually employed these animals. Although, however, it would appear probable that the inoculations of tubercle may produce active tuberculosis under almost all conditions, yet it by no means follows that there are no predisposing conditions which are influential in every-day life. The immunity of almost all wild animals from spontaneous tubercle is a fact never to be lost sight of. Here again, as in the case of plague, we seem to get a hint that free exposure to fresh air is prejudicial to the life of the bacillus. In dealing with the topic of tubercular affections of bones and joints in the human subject, Mr. Cheyne, although asserting the invariable presence of the parasite, did not at all ignore predisposing influences. I was much interested to hear him speak of scrofula as one of the most important. This is the definition which I have myself repeatedly tried to give to the word, "that state of constitution which favours the development of tubercular diseases" (see ARCHIVES, Vol. ii. p. 209).

The introduction of diseases of vegetables as a subject for a course of Lectures at the College of Surgeons was, I believe, a novelty. In the hands of Mr. Plowright it has been a complete success. His lectures on some of the parasitic affections of plants and trees were listened to with great interest and attention. The marvellous phenomena of heterœcism were, amongst many other topics, well illustrated. That some

discovery in this direction awaits us which shall explain the relations of ringworm and alopecia circumscripta I feel very confident. Every week's additional experience confirms me in the belief which I have long held, that the one is a consequence of the other. Yet the interval between the two may be many years, and is indeed rarely less than several.

It is much to be hoped that the great attention which the bacillary forms of vegetable life now claim will have for one result the restoration of the study of plants to its proper place in the medical curriculum. It was a great mistake, a definite step backwards, when botany was omitted from the subjects taught in our medical schools. It is really a subject not only of enchaining interest, but of the utmost use. We need to understand not only the part which vegetable organisms take in disturbing the health of animals and of man, but very important parallels to the latter may be found in the parasitic diseases of vegetables themselves.

The history of the potato-disease is in some of its features not dissimilar to that of true plague. The special fungus which causes the former can develop only under certain medium conditions of temperature. It is so with the hypothetical particulate virus of plague, which was for long held to be incapable of germination in the tropics, and concerning which it is still admitted that both great heat and great cold destroy its vitality. Thus, in some hot countries plague prevails in spring, and ceases when summer is well advanced, to return again, however, next spring. In cold ones the reverse is the rule; it begins in summer and ceases in late autumn. The remarkable manner in which plague lingers as an infrequent, or sporadic, disease for long periods and then suddenly bursts out as a wide-spread epidemic, is exactly like what we witness in the potato-blight. The latter has never wholly left us since its first introduction, but has prevailed extensively only during certain favouring seasons.

ON THE CANCEROUS PROCESS AND ON NEW GROWTHS IN GENERAL.

(Continued from page 144.)

An example of contracting Scirrhus of Breast—Both Breasts affected.

By far the most remarkable example of the form of scirrhus which contracts and atrophies which I have ever seen occurred in the person of a lady who was sent to me from Southampton. She had suffered from cancer of the right breast first, and the other subsequently, the beginning having been more than thirteen years ago. She had never had any open ulcer, but both breasts had disappeared, so that in each instance the nipple only remained. The latter was not reduced in size, but was retracted at its base and held down firmly to the chest wall. It is to be understood that every trace of the mammary glands had disappeared. On the right side, the whole mammary region was occupied by a thin, smooth, glossy scar, which extended backwards on the side considerably behind the mid-axillary line. Near to this large scar there were several other, quite isolated, patches of scar-like tissue, about the thickness of parchment, slightly rigid, and quite smooth and glossy on the surface. These were movable on the deeper parts, and in each instance the border of the scar was slightly elevated and presented a sinuous rolled edge like that of rodent. There was not a trace of ulceration anywhere, nor, let me repeat, had there ever been. On the border of the left axilla there was a subcutaneous lump about as big as a hazel-nut: this was the only instance of the growth showing any material thickness; everywhere else it was as thin as parchment. Two or three glands might be detected in each axilla, but they were scarcely larger than horse-beans.

When Mrs. P—— came to me she was in a state of urgent illness from what I diagnosed pleural effusion, her right chest being apparently full of fluid. This was, however, probably of quite recent development, for she assured me that until about a month ago when she thought she had taken cold in a country walk with her children, she had been in good health.

The case is not only remarkable on account of its tendency to atrophy in the mammary glands themselves, but in the very peculiar features which the secondary growths in the skin assumed, and from the absence in all the many positions which were affected of any tendency to ulcerate. The ser-piginous advance of the disease in the skin was, as noted, by a slightly elevated rolled edge like that of rodent ulcer, and it left behind it a thin scar, which, however, was probably not free from growth. I have seen rodent ulcer travel widely and very superficially and leave scar, but never, I think, wholly without ulceration. In the case of Mrs. ——, from near Bath, of which I have preserved a drawing, a process of disease travelled widely over one mammary region, presenting everywhere a rolled and elevated edge like rodent, but leaving the surface not in a condition of scar, but covered with level florid granulations. This case appears to me to be very analogous to the one now narrated, the difference being that in the one case cicatrization had followed the advancing disease, and the other a condition of persisting granulations. The latter were claimed by some who saw the case as a form of eczema of the nipple. It may be that some of the conditions which pass under the latter name are similar to those now described, and examples of a superficially spreading cancer of skin.

The sequel of the above case is of interest in reference to the diagnosis of fluid in the chest. As I have stated above, I thought that the pleura was almost full, and suggested to the surgeon by whom the case had been sent to me that tapping should be practised. This was done with great care and skill on two occasions, but no fluid was reached on either. It seemed clear that the dulness was caused by solid growth and not by fluid. This was the more remarkable on account of

the very slight tendency to growth externally. Mrs. P—— died about two months after the period to which my notes refer.

Cancer of Tongue following "white paint sclerosis" after a long interval.

A man named John G——, now aged 57, was under my observation at the London Hospital fourteen years ago, and a drawing was then made showing the state of his tongue. It was a case of abrasions and sclerosis of the tongue due to syphilis and smoking. I advised him not to smoke, and to a certain extent he abstained. There is now present (1891) on the left side of the dorsum an oval patch nearly an inch long, which is indurated, rough, and papillary. It is superficial, and there is not the least ulceration; its hardness is however very definite, and it has been increasing of late. There is decided enlargement of glands in the floor of the mouth, just within the angle of the jaw. The right side of his tongue is in the white paint condition. He has a little aching pain in the tongue, and occasionally a little itching. During the interval since I saw him he has not needed treatment, and has not had much advice for it.

There is not the least doubt that epithelial cancer has now developed, and the case becomes of interest, because I now possess two drawings showing the conditions with a fourteen years' interval. The first portrait shows large patches which are smooth and white, exactly as if paint had been thickly applied. With these in other parts are some abrasions. The second portrait shows definite papillary growth budding through one of the thickest patches. As the man has advanced towards senility so have the local processes developed towards cancer. It is to be feared that he has waited too long, for the lymphatic glands are now enlarged. It is needless to say that on the second occasion I advised immediate removal of the tongue and excision of the glands.

DISEASES OF THE EYE.

No. XV.—*High degree of Myopia, stationary through a long life, and in spite of much use of the eyes and enfeebled health.*

WE are accustomed to hold so strongly the belief that over-use is the main cause of aggressive myopia, that it is well to ask attention now and then to exceptional facts. One of the worst cases which I have seen, in which the elongation of the globes advanced so as to bring about blindness with detachment of retina in comparatively early life, occurred in a costermonger who could neither read nor write. In the sub-joined narrative we have a converse fact.

Mrs. D—— married at 21, and was then, so far as she remembers, as shortsighted as she is now at 58. She always passed her friends, and even her own children, in the street. Her sight was, however, excellent, and she used her eyes constantly. "If I laid my book down I always took up my work." Suddenly at the age of 58 she found the right eye defective, and saw "a cloud of gnats" before it. This was explained by a small hæmorrhage into the vitreous. Although up to this date Mrs. D—— had always boasted of the excellence of her sight, and been able to read print which others could scarcely see, I found in both eyes extensive peripheral lens changes, and a small opacity at posterior pole. She had never in her life used spectacles. Her myopia at 58 was $-4''$ (or 10 D). This case shows that excessive use of myopic eyes and abstinence from glasses may be coincident with stationary myopia. That the myopia had not increased is the more noteworthy because Mrs. D—— had, through ten

years of middle life, been frequently exsanguined by profuse floodings, and during the next ten had to encounter much sorrow through the long illnesses in phthisis of her two daughters. It may be noted that not a hair had turned grey, but she had become liable to general œdema (? myxœdema).

No. XVI.—*Eczematous Conjunctivitis.*

It is not often that one sees a good example of true eczema of the eye. I mean by that term a disease of the same nature as eczema of the skin. When eczema attacks the face, it very usually spares the eyelids. The case of Miss R—— of Blackheath, who was sent to me by Mr. Herbert Burton, appeared to offer a good example of this condition. She suffered from very severe eczema of the ears. The whole of each ear and of the region behind it was affected—the right ear the most severely. I was told that when an infant she had suffered from eczema of the scalp and face very badly indeed, but had got quite well with the exception that the disease lingered about her ears. On these parts, however, she had not suffered much of late years; the present attack was only of a few weeks' duration. The right eye was inflamed. The conjunctiva of both lids and globe was much congested and slightly swollen. The redness was less near to the margin of the cornea than elsewhere, and there were neither ulcers nor pustules. The edges of the eyelids and the surface of the skin for about a quarter of an inch from the edges was red and excoriated (eczematous). The eyelashes, although surrounded by eczema, were not specially involved—that is, there was no sycosis. The other eye was not affected.

No. XVII.—*Ophthalmitis (pyæmic?) after parturition—Recovery, with loss of the eye.*

I saw Mrs. C—— at Sydenham in consultation with Dr. Wilkinson, of that place. She had been confined two weeks before my visit. Her labour had been long and difficult, but she was believed to be doing well during the first two days, when she was subjected to a severe mental disturbance, after

which tenderness of the abdomen followed, secretion of milk stopped, and she became very ill. During the next week she was, as Dr. Wilkinson assured me, in a very critical condition, with rapid pulse, brown tongue, and great abdominal tenderness. About ten days after her confinement, a week from the beginning of her febrile symptoms, and at a time when the latter were beginning to subside, the left eye inflamed. She had great pain in it, and her sight rapidly became indistinct, the lids being also much swollen. At the time of my visit on Tuesday, June 20, 1871, the eye was quite lost; she could not distinguish light in the least. The cornea was hazy, the iris muddy, and the pupil occluded with lymph. There was considerable congestion of conjunctiva, and by effusion into the cellular tissue of the orbit the eye was pushed forwards. The upper lid was tense from swelling; indeed, the aspect of things suggested the possibility of an abscess in the orbit, but on careful examination I could not detect any evidence of such being present. At this date the abdominal symptoms had quite ceased, and our patient might be considered out of danger. The other eye was free from inflammation, and there had been no symptoms of joint or visceral mischief, other than those connected with the uterus. Our patient was a lady of about 30 years of age, who had previously borne several children. It may be noted that she had cried a great deal since her confinement, and that her friends were inclined to believe that this had excited the disease in her eye. There can be little doubt, however, that the ophthalmitis was due to blood poisoning, and was secondary to the puerperal metritis. It is curious, if we adopt this hypothesis, that the usual symptoms of pyæmia were absent, that the patient had had no very definite rigors, and that she made a satisfactory recovery. Her case may, perhaps, be suitably compared with those of panophthalmitis which we now and then see in children after chicken-pox, &c.

Mrs. C—— called on me two months later, having regained tolerable health. Her eye was quite blind, the pupil everywhere adherent; but the globe had not materially shrunk.

Cases of loss of the eye in connection with fatal puerperal fever are met with occasionally. Mr. McCarthy has mentioned

to me one which occurred whilst he held the obstetric appointment at the London Hospital. In this both eyes inflamed, and the woman had at the same time symptoms of pyæmia, from which she died.

No. XVIII.—*Syphilitic Keratitis in two sisters—
Result fifteen years afterwards.*

I attended two girls, sisters, aged respectively twelve and ten, for interstitial keratitis. In both of them the attack was severe and protracted. The elder one had typical teeth, the younger one not. The elder one had synovitis of one knee, at the time of the attack in the eyes. I had an opportunity of examining these patients' eyes fifteen years afterwards. They had both of them enjoyed excellent sight ever since, and their corneæ were perfectly clear. I examined the choroids in each with care, and could find no trace of disease. The elder one at this latter date seemed threatened with a second attack, for a small but very definite salmon-coloured patch had formed on the uppermost edge of one corneæ. Neither of them had had any periosteal disease or any other ailment.

No. XIX.—*Syphilitic Keratitis—Both eyes lost.*

In contrast with the above I may just mention the case of a poor boy, Alfred Leach, aged 13, in whom both eyes were lost by syphilitic keratitis. The attack had lasted twelve months. His corneæ, when I saw him, were shrunken, and the globes collapsed. Loss of the eyes from syphilitic keratitis is of course a very rare event. That it does occasionally happen, however, this case proves. I have seen a few others.

MISCELLANEOUS.

No. XVII.—*On Intestinal Croup or Membranous Enteritis and its differential diagnosis from Gall-stone Colic.*

The following extract is from a paper by Dr. Richard Powell, published in 1820 in the “Medical Transactions of the College of Physicians.”* It is possibly the earliest description of recurrent membranous enteritis which we possess. I am especially interested in it because the author believes that attacks of this nature are apt to be mistaken for those of the passage of gall-stones. Dr. Powell begins by stating “Whenever violent pain takes place in the epigastric region of the abdomen, exacerbating in paroxysms accompanied by sickness, yellowness of the eyes and skin, and urine, by clay-coloured fæces, and without any proportionate increase of action in the circulation, biliary concretions are supposed to be forcing their way through the ducts; and when these symptoms abate, it is inferred that their passage into the duodenum has been effected.”

* I cannot resist the temptation to quote the title of the first paper in this volume, as indicative of the practice of the day, and of the degree to which the separation of medicine and surgery was then carried out. It runs, “*History of a Case of Strangulated hernia successfully treated by the application of Ice after the attempt at Reduction by the Taxis had failed,*” by — —, F.R.S., M.D., Fellow of the Royal College of Physicians. One of the most valuable papers is by Edward Stanley, then Assistant Surgeon to St. Bartholomew’s Hospital and Demonstrator of Anatomy. These volumes of Transactions have excellent illustrations. As a hint to the present zealous and active President of the College and his colleagues in office, I will reprint the “advertisement” which appears on the fly-leaf of the volume:—“*The College of Physicians of London are ready to receive any medical papers which shall be presented to them, in order to publish the most useful. Papers intended for the Transactions may be sent to the Registrar.*”

After this the author proceeds to state that he has often been disappointed of finding a gall-stone in the fæces, and has found instead what he proceeds to describe:—

“In the cases to which I refer, this residue has exhibited a large quantity of flakes mostly torn into irregular shapes, and appearing to have formed parts of an extensive adventitious membrane of no great tenacity or firmness. In the first of the cases which came under my notice, this membrane was passed in perfect tubes, some of them full half a yard in length, and certainly sufficient in quantity to have lined the whole intestinal canal. In the others also the aggregate quantity has been very large, and it has continued to come away for many days, but it has been in irregular thin flakes of not more than two inches extent, and not, as far as I could discover, of the perfect tubular form (which would probably also have been broken down by the agitation in water, if it had existed on its first passage out of the body). I have definitely examined four such cases, in all of whom the leading symptoms have been similar, and have led me to suspect the passage of biliary concretions at the time. They have all been adult females, and have occurred in private practice. I had attended but one of these previous to this particular attack, and she had frequently suffered from occasional pain in the intestines and derangement of her powers of digestion, with flatulence and a sense of suffocation. She was always relieved at the time by mild opening medicine, and believed herself able to prevent the attacks.

The more violent seizures under which I saw all the patients, consisted in a sudden and excessive pain in the epigastric region, increasing in paroxysms very frequently, rather relieved by pressure of the patient herself at the time, but leaving great soreness and tenderness during the intervals. This state continued under four days; during it the stomach was very irritable, and the tongue coated and clammy. Jaundice came on at an early period, and the stools were white, brown, or somewhat greenish, and streaked in colours, until the films began to pass, when they were mixed with a full sufficiency of bile, but not at first of a healthy colour.”

After some statements as to the great advantage which he had obtained from the use of laxatives, Dr. Powell adds:—

“The formation of adventitious membrane has not been so frequently observed in the intestinal canal as it has in circumscribed cavities; and I know not that any description of the symptoms accompanying such a state has heretofore been given. The appearance which comes nearest to it, both in resemblance and situation, is the membrane formed in the trachea under croup, but the symptoms are there more violent and destructive from locality of situation.”

The suggestion occurs that it is possible that in some of these cases a *bonâ fide* attack of gall-stone colic may have been the cause of the membranous enteritis. The explanation of the severe pain suffered in the early stage is not otherwise easily given. It may be that Dr. Powell (and many others with him) was wrong in the expectation that all cases of gall-stone irritation are followed by the passage of the stone. He adverts to the well-known fact that in most cases in which calculi are found after death in the gall-bladder, all history of attacks of colic is wanting. It may, however, not improbably be the fact that many attacks of gall-stone irritation end by the slipping back of the irritating calculus. The bile itself of course passes in both directions at different times, and we may without difficulty imagine a stone impacted for a time in the first part of the duct, and causing irritation, but not so fixed as to be incapable of slipping back again. Be this as it may, it is important for us to know and remember that an observant physician, who was in the habit of carefully inspecting the feces, found that, in certain cases which he had diagnosed as gall-stone irritation, evidences of membranous enteritis were present, and that no stone could be discovered.

I have myself recorded in the Pathological Society's Transactions for 1857, Vol. IX., page 188, a remarkable example of long-continued proneness to void tubular exudation-casts of the large intestine. The paper is enriched by a detailed account of the microscopic characters of the casts, by Dr. Wilks and Dr. Andrew Clark. The patient, a lady of

49, was liable to alternations of obstinate constipation and diarrhoea. I have since then seen several similar cases, and can confirm most of Dr. Powell's statements.

No. XVIII.—*Spontaneous Gangrene of the Penis a quarter of a century after very prolonged exposure to severe cold.*

I know of no Medical Journal in which so much information is so agreeably condensed into so short a space as in the Reports of the Northumberland and Durham Medical Society. They are, in my judgment, models of what such reports ought to be. The Number which I have just received consists of only nine pages, yet it contains most valuable statements of evidence as to the non-importance of the supposed cancer-fungus, the comparative inefficiency of Koch's treatment of lupus; and the possibility of recovery from tubercular meningitis. It has also case-reports proving that injections per anum may pass the ileo-cæcal valve, and that ivory pegs may remain unaltered in the tibia for eight years. There are further an example of recovery after ovariectomy at the age of seventy; of a good result after excision of the rectum; and others of recovery after removal of the cæcal appendix, and after operations for fœcal fistula and for gall-stones by choleo-lithotomy.

The case, however, which has interested me most is one, by Dr. Hume, of spontaneous gangrene of the penis in a man who, nearly thirty years before, had lost both legs by gangrene after six days' exposure on a raft. He was sixty-six years of age when the entire penis passed into gangrene, and he was at the time confined to bed by subacute bronchitis. The organ sloughed off with but very little pain. Dr. Hume records that he can find no record of spontaneous gangrene of the penis excepting in connection with fevers. In recording a case (ARCHIVES, vol. ii. p. 250) in which an old gentleman suffers from disturbed nutrition in his hands and other conditions allied to Raynaud's malady, I urged that it was probably a factor of some importance that he had many years before been exposed to very severe cold and suffered from frost-bite. So also in Dr. Hume's case I should incline to believe that it was by no

means a mere coincidence that gangrene of the leg had preceded that of the penis, although the interval was so long. In the first place, probably both implied that the man was congenitally of feeble circulation, and in the second it is likely that the prolonged exposure which caused the legs to slough inflicted permanent damage upon the nutritional vigour of the blood-vessels, nerves, and tissues generally, from which they never wholly recovered. There is an important lesson in the case.

No. XIX.—*The effect of Imagination on the influence of Drugs.*

I have had a few patients who aver that they cannot take nux vomica, because it always makes them feel sick. They are usually more or less intelligent persons who read their prescriptions, and who lay stress on the word *vomica*, fancying that it has something to do with an emetic. Those who speak of it as “nux” only always like it.

No. XX.—*Ague before the days of Quinine—Cirroid Aneurism—Liability to Catarrh, &c.*

“I had not been here two days before a Quartan Ague set on me, which held me for a year and a half without intermission, and a year and a half longer at Spring and Fall. The good days I had during all this sickness I employed in Study, the ill being spent in as sharp and long fits as I think ever any man endured, which brought me at last to be so lean and yellow, that scarce any man did know me.”—*Lord Herbert's Autobiography*, temp. 1620.

Lord Herbert (of Cherbury), in his entertaining autobiography, gives some further interesting particulars as to his own bodily peculiarities.

In childhood he had discharges from his ears. In middle age he believed that he grew an inch taller; his tailor first drew his attention to it. He thought that it was explained by a remarkable rejuvenescence and improvement in health which had followed on his recovery from the quartan ague above described.

He believed that he was of a lighter specific gravity than most men, having often weighed against those who were a head shorter "and in their bodies slenderer," and always "found himself lighter than they."

He states, "I have had through life, and have still, a pulse on the crown of my head." He believed that his perspiration and breath were exceptionally free from smell, although he used tobacco "against certain Rheumes and Cataares."

He states that he scarce ever felt cold in his life, "tho' yet so subject to Catarres, that I think no man was ever more obnoxious to it." After detailing these particulars, he adds: "All which I do in a familiar way mention to my posterity tho' otherwise they might be thought scarce worth writing." He lived 1562 to 1648.

No. XXI.—*An instance of Restricted Secretion from Skin and Mucous Membranes.*

In the autobiography from which I have taken the above extracts, Lord Herbert of Cherbury gives the following quaint description of certain peculiarities in Louis XIII. "His words were never many as being so extream a Stutterer, that he would sometimes hold his Tongue out of his Mouth a good while before he could speak so much as one word. He had, besides, a double row of Teeth, and was observed seldom or never to spit or blow his Nose, or to sweat much, though he were very laborious, and almost indefatigable in his exercises of Hunting and Hawking, to which he was much addicted. Neither did it hinder him though he was burst in his body, as we call it, or Herniosus; being equally insensible, as was thought, either of heat or cold."

No. XXII.—*A spreading Mole.*

A young gentleman, who was sent to me by Mr. Huxley, of Torquay, presented an interesting example of an aggressive mole. It affected the left parietal region and was of considerable extent, covering an area almost as large as a child's palm. It was almost flat on its surface, and about an eighth of an inch in thickness. It presented here and there, but especially

at its margins, little fleshy fingerlike projections, such as I have seen in what I have ventured to name the cock's-comb mole. It was everywhere quite pale excepting at its edges, where, as already stated, it was actively aggressive. Here the little fimbriæ were many of them distinctly vascular, and on being magnified showed small tufts of dilated vessels, exactly like those seen in lupus lymphaticus. I did not, however, detect any distinct vesicles. The fact that the disease was spreading at its edge probably showed some alliance with the last-named malady, or even with common lupus. It had not, however, ulcerated in the least. As the young gentleman is going to reside in Australia, I shall probably know nothing further of the case. My treatment consisted in a very liberal application of nitric acid.

No. XXIII.—*Attacks of Arterial Anæsthesia of the feet of such severity as to make it difficult to walk.*

I have suggested the term Arterial Anæsthesia for a form of numbness which results from defective supply of blood, and have distinguished it from loss of sensation resulting directly from the nerves, by asking attention to the fact that it is never located according to their distribution. The illustrations of arterial anæsthesia which I have thus far given in the ARCHIVES, have been exclusively in the feet. They have all been denoted by the remarkable phenomenon of numbness, limited by a line drawn round the foot a little below the instep. In some cases the numbness does not extend so high, affecting only the toes, but in all it is bounded by a circular line and involves equally all parts below it. It is emphatically anæsthesia *ab imo*.

The best illustrative case which I have adduced was from a patient in whom a popliteal aneurism became suddenly occluded, and the blood supply to the foot was cut off mechanically. Another was from a case of locomotor ataxy, a disease in which the symptom not infrequently occurs. I believe that this kind of numbness, as a temporary thing and due to functional conditions, is very common. A very

definite example of it has come under my observation since my last note.

A lady of 58, of very feeble circulation, with weak heart and diseased arteries, complained to me bitterly that whilst walking her feet would often become numb. "It is not," she said, "the whole foot, but all the front of it, as if it were across my knuckles in my hand" (showing me her hand). "Both feet go at once, and I lose feeling to such an extent that I feel quite insecure in walking." She added, "It comes on whenever I am in the least cold, or from any little shock. I never get through a day without it." This lady had, I found, been accustomed for more than a year to carry about with her the nitrite of amyl capsules, which had been prescribed for her on account of very alarming attacks of a sort of angina which she had formerly experienced. During these attacks she became, she said, deathly pale, and those who saw her thought she was dying. Under long continued use of a prescription containing nux vomica, digitalis, and æther, she has been for a year free from these attacks. During the last three months, however, the liability to loss of sensation in the distal portions of her feet has come on as above described.

These cases differ from Raynaud's phenomena in that the duration of the condition is far shorter, and thus no risk of gangrene occurs. The attacks may be over in a few minutes, or at most in a few hours. I am not aware that they are ever attended by lividity.

No. XXIV.—*On large Arteries in Elderly Persons.*

The Rev. Mr. C—— affords a most remarkable example of general enlargement of arteries. He is a short, thick-set, florid man, and by no means emaciated. I can, however, count his pulse almost anywhere, so general is the increase in size in his arterial system. The radial can be felt very easily on the back of the interspace, and the superficialis volæ on both sides beats so vigorously that it might be mistaken for the radial itself. His temporals are enlarged in a like degree. There is no great evidence of tortuosity of vessels anywhere. Those of his lower limbs appear to be equally affected with those of

the upper. Both anterior and posterior tibials can be felt with the greatest ease near the ankle, and are two or three times their normal size. Mr. C—— is in good general health; his heart is of course somewhat enlarged, but he does not suffer from any special cardiac symptoms. He is of gouty stock, but has never himself had gout. He is a man of great intellectual power, and has, I expect, lived with moderate freedom. He is sixty-three years of age. He has several times consulted physicians on account of sudden failures of memory and loss of speech. The two things have occurred independently of each other, and at different times. His loss of memory has chiefly been noticed at family prayers, when he would absolutely forget sentences with which he was perfectly familiar. His loss of words or inability to express himself clearly has several times much alarmed his wife. Once it occurred just when he reached home after some little fatigue in walking, and on another occasion in the night when he had got out of bed.

I feel sure that a condition of general enlargement of the arteries in persons past middle life is not a very unusual condition, and that it is often independent of heart disease. It does not in some cases appear to involve any special risks, excepting, perhaps, of arteritis and thrombotic plugging.

No. XXV.—*Milium in a Baby.*

Mr. I——'s infant had her face and front part of scalp covered with little white milium spots, none of them in the least inflamed. They were said to have been present from birth. There were a few on the neck, trunk, and limbs. The face was covered. It was asserted that there were not so many now as at first. The little white spots were raised, and evidently contained a minute speck of sebum. The child was suffering from inherited syphilis, but I doubt whether the milium had anything to do with that disease.

No. XXVI.—*Lumbago.*

The Germans call lumbago Hexenschuss or the witch's spell, in reference to the extreme suddenness with which its attacks

of disabling pain come on. Niemeyer tells us that the wry faces, contortions, and the curious expedients to avoid bringing on the pain excite laughter as well as pity. He speaks of the disease as a rheumatism of the lumbar muscles and of the lumbo-dorsal fascia. Ten or fifteen lines are all that he devotes to its description. Graves, however, the prince of clinical observers, treats the malady much more seriously, discussing its pathology and causation at considerable length. He had himself suffered from it, and he evidently thinks a lumbago patient ought at once to take to his bed, and be freely cupped. From the general tenor of his statements we might infer that the disease is both more common and more severe in Dublin than in Germany.

No. XXVII.—*Fibrinous formation in the Ileum—
Perforation of Appendix with local adhesions, &c.,
but no fever—Death after a week's constipation.*

Dr. Markham Skerrett, of Bristol, has recorded in the Clinical Society's Transactions a remarkable case in which a fatal attack of obstruction was caused by fibrinous effusion into the ileum, three inches above the ileo cæcal valve ("exactly like the false membrane in croup.") There were also peritoneal adhesions and an abscess cavity. The attack had lasted one week, and had been wholly unattended by fever. It had begun with pain and sickness. On the first day there had been diarrhoea, but constipation ever afterwards. It appeared almost certain that perforation of the vermiform appendix had been the starting point.

In commenting upon the obscurity of the symptoms, Dr. Skerrett states that in his experience febrile symptoms are often absent in serious abdominal cases, and writes: "I have seen, again and again, patients suffering from acute general peritonitis almost free from local and general symptoms."

No. XXVIII.—*Notes on the Indian climate as suitable for the permanent residence of Europeans.*

I obtained from Colonel M. C——, a very intelligent man who had lived much in India, some information in reference

to his experience of the Indian climate, and more especially as to whether the hill stations offered attractions as places of permanent residence for Europeans. He said that Europeans were settling there, retired officers, &c., much more frequently than formerly, but that it was the depreciation of the rupee, and not the climate, which was the inducement. The rupee would buy as much in India as ever, whilst if you brought it to England you lost thirty-seven per cent. of its value. Were the hill resorts good for children? I asked. He believed that hill-bred children were not a success. The rarefaction of the air, and the rapid changes from intense sun heat to intense cold, were very trying to invalids; and it was necessary to live most carefully both as regards clothing and exposure.

Seven thousand feet was about the height of the best stations. Was it not possible to find healthy places much lower down than this? I asked. Not much, was his reply; five thousand feet was the lowest range to be out of range of fever. The ravines of the mountain slopes, through which the roads of ascent lay, were many of them more unhealthy than the plains below. No places were more deadly as regards malaria than some sites of this kind half way up the mountains. (Exactly the same report was given me respecting ravines in Corsica when I was there some years ago.) Colonel C—— did not intend to retire to the hills himself when his time was up, but return to England. He had a prejudice against climates where the sun was very hot, while the air was very cold. He mentioned sleeplessness as a very remarkable and very constant phenomenon in new arrivals at the hills. He said that some persons would be for a week with scarcely any sleep.

It was customary to try and become acclimatized in this respect by staying for a week or two at a somewhat lower station, but this must not be done at anything less than 5000 feet. He mentioned halting places somewhat lower than this, at which he should consider it equivalent to death to sleep. As regards the insomnia caused by hill air, it is a well-known result in many persons in the Swiss mountains; and it even occurs to some extent in such places as Malvern and Buxton.

No. XXIX.—*Dr. Heuss' portrait of extensive destruction of skin and cellular tissue from Syphilis.*

It is remarkable how often by patient waiting and continued observation we are in the end rewarded by discovering a parallel to what had at any rate appeared to be, if not unique, most exceptional. Those who have visited the new Gallery of Illustration in the College of Surgeons Museum may possibly have observed a portrait of a woman with her amputated arm by her side. The latter is shrivelled, and the whole of its skin in a state of scar. On the patient's body in many other parts are large scars from destruction both of skin and subcutaneous cellular tissue. The portrait, which is, I must confess, but very poor as a work of art, is yet of great clinical value, for it illustrates a most extraordinary development of disease. It is from Heuss' Atlas of Surgical Illustrations. Its discovery at once brought to my memory a case of which the following are the notes.

No. XXX.—*An extraordinary form of serpiginous destruction of subcutaneous tissue and skin, with atrophy of muscles; the disease spreading slowly for ten years, and still in progress.*

The patient, a woman, æt. 56, describes the disease as having commenced ten years ago as small subcutaneous lumps, some of which suppurated and some spread. The first which showed themselves were on the shoulder. It would appear that a succession of these swellings formed. Large sores afterwards formed at various places. They healed under poulticing, and with no specific treatment. She was engaged at the time in a furnishing shop, and she thought that the disease was probably due to strains. It would appear that these subcutaneous abscesses gradually extended upwards and downwards, and that they involved the muscles as well as the skin and cellular tissue. The result has been the production of an extraordinary condition of things. The whole of the upper extremity, from the middle of the forearm to the base of the scapula, is in a condition of irregular scar. In many parts

the scar is exceedingly thin. It is thinnest of all just over the shoulder, and the deltoid muscle having been entirely destroyed, the margins of the acromion and the head of the humerus, with its tuberosities, can be easily seen under a scar scarcely thicker than brown paper. Yet the joint is not ankylosed, and its capsule apparently has not been interfered with. The coracoid process is quite visible, projecting under the scar. The morbid processes appear to have come to an end near the shoulder, but it is uncertain if they are not still spreading upwards. Her little, ring and middle fingers are drawn up into the palm.

The case which I have narrated was brought under my notice by a friend many years ago. She was never my own patient, and I saw her but once. It will be observed that it was a form of infective and serpiginous inflammation of the cellular tissue rather than of the skin. The latter was involved secondarily. In Dr. Heuss' case, mentioned above, there was a history of syphilis, but specifics failed to cure. In mine I could get no such history, and the sores had besides healed without specific treatment. There was nothing in the least like lupus of the skin, whether common or specific. Nor are either of the cases at all like any of the ordinary forms of scrofula. The tendency of the skin to shrivel and cicatrise was a most remarkable feature. Nowhere did it present the undermined ragged edges so often seen in strumous ulcers. On the whole, probably the most likely supposition is that both were instances of a serpiginous syphilitic inflammation of cellular tissue.

A CATECHISM OF SURGERY ; WITH CASES FOR DIAGNOSIS.

No. LXI.—*A Cerebral Case for Diagnosis.*

A gentleman of 23 who, as a consequence of rheumatic fever, had valvular disease of heart and hypertrophy, was one evening driving in a gig. Suddenly the reins dropped from his left hand. His companion took them and asked him to change seats. He tried to do so and fell on the splash-board, being weak in his left limbs. An hour later he got out of the gig with but little help and walked into the house. He was found next morning unconscious, and with the left limbs quite paralyzed and the left side of face also. On regaining consciousness, after a few days he was quite hemiplegic as regards motion, and sensation in the whole left half of body, limbs, and head was defective. He could not retain his urine or feces, he was deaf in left ear, and had lost smell in left nostril and taste in left half of tongue. His sight, so far as he knows, remained perfect. He was six weeks in bed, and then gradually recovered. Eight months later he could walk fairly well, had recovered perfect hearing, smell, and taste, and the only trace remaining of his facial paralysis was inability to shut the left eye without shutting the other. His arm was still in a sling and its motions imperfect, but it was improving and there was no contraction. He was just beginning to use his fork at meals.

DIAGNOSIS.

Clearly it was a case of embolism of the right middle cerebral artery. In the first instance the obstruction was probably not complete. During the night, coagulation of blood around the embolic plug made the obstruction complete

and developed the hemiplegia. It is remarkable that the hemiplegia involved the tongue, face, and hearing. This implied that a large extent of cortex was deprived of blood. Recovery took place in part by restoration of the blocked channel, and in part by collateral circulation.

No. LXII.—*Nodi Digitorum and Gout.*

1. What is meant by the the term Nodi Digitorum ?
2. How would you distinguish between Nodi Digitorum and the chalk-stones of gout ?
3. Do conditions similar to those called Nodi Digitorum when met with in the fingers occur in other parts ?
4. How would you diagnose the conditions represented in the appended woodcut ?



ANSWERS.

1. Nodi Digitorum is a term used for the bony enlargements which occur about the joints of the fingers in cases of rheumatic gout. It was first employed by Heberden.
2. The enlargements of nodi digitorum are osseous. Those of gout consist of the deposit of urate of soda ; a mortar-like concretion.
3. Yes, the conditions which constitute arthritis deformans in the knee, hip, ankle, &c., are of the same nature as those which cause deformities about the joints of the fingers ; consisting of outgrowths from the articular extremities of the bones concerned, with other alterations in their shape.
4. The woodcut very clearly shows true chalk-stones as distinguished from nodi digitorum. The swellings are large

and rounded, and do not keep closely to the joints themselves. They are also very variable in size in different parts. *Nodi digitorum* are usually of much more regular and uniform development. They occur only in connection with the joints themselves, and never assume the large size and rounded contour of those shown in the woodcut.

No. LXIII.—*A Case for Diagnosis.*

A gentleman aged 30, who five years ago was under my treatment for syphilis, now complains that there is a mist before his sight in reading which obliges him to shut the right eye. He has no inconvenience in walking, it is only when reading; and the mist disappears when the right eye is closed. He finds himself habitually reading with the affected eye shut. He has perfect vision in the distance with each eye singly, but when he tries to read small print he finds the right eye a little defective. The ophthalmoscope reveals nothing. The pupils are of normal size, but possibly a little sluggish. He has no other nervous symptoms, but once, some years ago, had a temporary weakness in the right hand. His reading vision with his right eye is quite restored by a + 14" glass. The condition referred to has been present for three months.

QUESTIONS.

1. What do the conditions described imply?
2. What may this symptom portend?
3. What other symptoms should be looked for?
4. What are the conditions which constitute *ophthalmoplegia interna*?
5. What should be the treatment?

ANSWERS.

1. The conditions described imply a recently developed inability to effect complete accommodation with the right eye (imperfect cycloplegia). Hence when the type is brought to the proper focal distance for the better eye it is too near for the other, and a mist is perceived.

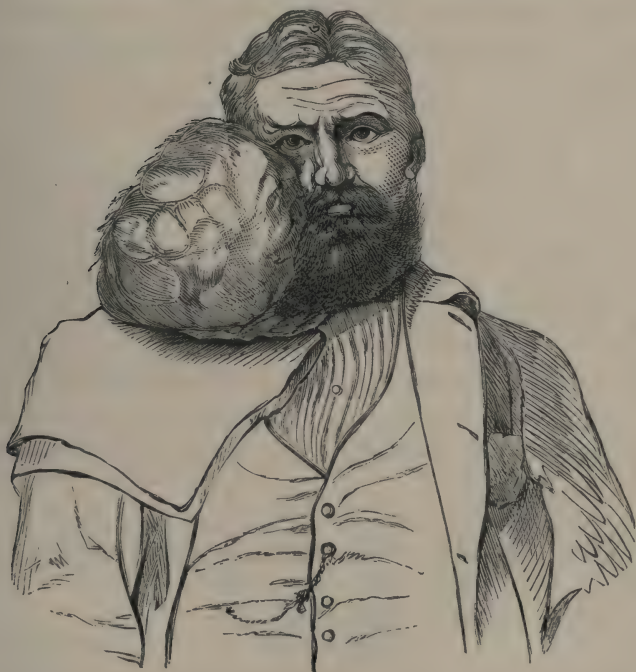
2. It may be part of *ophthalmoplegia interna* and an early symptom of locomotor ataxy.

3. The other indications of ataxy should be inquired for. The pupils should be carefully examined from time to time as to their activity, and the knee-jerks should be tested.

4. The conditions which make up ophthalmoplegia interna are motionless pupil, neither contracted nor dilated, and entire loss of accommodation.

5. As the patient had suffered from syphilis, a long course of small doses of mercury should be given.

No. LXIV.—*Explanation of Woodcut.*



The portrait furnishes a good illustration of the large size to which parotid tumours sometimes grow. It is from a photograph, for which I am indebted to the late Sir William Ferguson; the patient being a gentleman from India, in whom the tumour had been slowly increasing for twelve or fourteen years. It was excised in King's College Hospital, and proved to be, as usual, partly fibrous and in large part

cartilaginous. I possess another photograph, given me by Mr. Edwards, of Keston, which shows a tumour at least three times the bulk of that exhibited in the woodcut. In Mr. Edwards' case it hung down upon the man's shoulder. In this instance it had been growing for more than twenty years, and although the man had retained good health through this time it finally caused his death by ulceration and sloughing.

These tumours begin over the parotid, but by their weight in process of growth they tend to travel downwards and leave the side of the face. It is important to remember that the larger they have become the more rapid is their growth. The great inconvenience which their mere bulk finally causes supplies a strong argument in favour of early removal by operation.

No. LXV.—*Rheumatism and Gout.*

1. Is the term Rheumatic Gout a correct one?
2. What is the distinction between rheumatism and gout in reference to the causes of each? Which is the more common?
3. What is the most characteristic pathological evidence of gout?
4. Do the tendencies to gout and rheumatism really mix?
5. Mention an instance in proof that the phenomena of inherited gout may differ from those of the acquired disease.

ANSWERS.

1. The term "rheumatic gout" is very appropriate to a large number of cases, since the patients are suffering from gout and rheumatism at the same time.
2. A patient is the subject of gout if he is liable to affections of his joints, fascia, eyes and other parts, in direct connection with articles of food. He is the subject of rheumatism if he suffers from similar affections in connection with changes of weather and exposure to cold and damp. Rheumatic liabilities are far more common than those of gout; and probably very few become gouty who are not more or less rheumatic also.
3. The presence of urate of soda is characteristic of a gouty

inflammation ; but probably many of the slighter forms of gout are unattended by any such deposition.

4. Under the influence of hereditary transmission, liabilities to both gout and rheumatism may become inextricably mixed and complicated, and peculiar forms of disease may be produced.

5. There is a peculiar form of recurring iritis, ending in destruction of the eyeball, which occurs only in the children of gouty parents. It is not usually associated with any of the ordinary phenomena of typical gout ; and there is never any proof of the deposit of urate of soda.

No. LXVI.—*Landry's Disease.*

1. What is Landry's disease ?
2. What are its causes, and what its pathological anatomy ?
3. What is the usual duration of the disease ?
4. May recovery take place ?
5. Is Landry still living ?

ANSWERS.

1. In 1859 Landry described an acute ascending paralysis which involved motion solely. Beginning in the legs, it ascends and implicates the trunk and arms, even extending to the muscles innervated from the medulla and pons. In most cases it ends fatally by paralysis of the respiratory muscles.

2. No special cause is assigned, and what is most remarkable, the disease has no anatomical lesion. No changes whatever have been discovered in the cord. Sensibility is but slightly impaired, and the voluntary muscles retain their electrical excitability.

3. The disease has an average of about ten days, but may end in death as early as the third.

4. In a few cases recovery has taken place.

5. Dr. Landry was born in 1826, and died in 1865.

No. LXVII.—*The Tonsils and their functions.*

1. Of what substance do the tonsils consist ?
2. Is it probable that they absorb or secrete ?

3. In what other regions is similar gland substances met with ?

ANSWERS.

1. They belong to the lymphatic system, and consist of masses of adenoid tissue containing many vessels and lymph-channels.

2. Mucous glands are embedded in them, but they have themselves no proper excretory ducts. It is quite as likely that their function is that of absorption as that of secretion, but to some extent both may take place. Their crypts are lined by a thick layer of squamous epithelium.

3. Masses of similar tissue are found in the palate, pharynx, and root of tongue. They may perhaps be regarded as the birthplace of leuco-cytes (Hingston Fox).

No. LXVIII.—*Causes of Nasal Voice.*

1. Under what conditions does speaking through the nose—"nasal voice"—occur ?

2. Does it always imply paralysis ?

3. Of what local diseases may it be symptomatic ?

4. Of what constitutional disease is it a frequent consequence ?

ANSWERS.

1. If during speech the soft palate be not drawn up and applied to the posterior pharynx so as to shut off the nasal cavities, the voice will in part pass through the nostrils and produce the well-known nasal twang.

2. Its occurrence may imply either sensory or motor paralysis, or it may be only the result of habit.

3. It may also be due to perforation of the palate, to post-nasal adenoid growths, or to enlarged tonsils.

4. It is common in the paralysis which follows diphtheria.

No. LXIX.—*Morbus Coxæ Senilis.*

1. What is the nature of the disease to which the name Morbus Coxæ Senilis is applied ?

2. What are its most conspicuous symptoms ?

3. What are the conditions found on dissection of the joint ?

4. With what disease is it often confounded ?
5. Ought the subject of rheumatic arthritis to be allowed to use his limb ? Ought splints to be applied ?

ANSWERS.

1. This term is applied to rheumatic arthritis of the hip joint (rheumatic gout), which is most frequent in elderly persons.

2. The earliest symptoms are pain and stiffness at the hip. These gradually increase, the buttock becomes flattened, the pelvis more or less distorted, and the limb may be shortened. Creaking in the joint during walking is often conspicuous in the later stages. Inability to get at the foot for the purpose of putting on the boot is a very characteristic symptom from the earliest period.

3. These vary according to the stage of the disease. The growth of a lip, at first cartilaginous and afterwards bony around the articular edge, is one of the earliest. Subsequently fringes may develop in the synovial membrane, the articular cartilage may be absorbed, the head of the bone eburnated, the neck shortened, and osteophytes (“pedunculated outgrowths of bone”) produced.

4. It is constantly confused with sciatica. Most cases which are diagnosed as persisting sciatica are really rheumatic arthritis of the hip.

5. The patient should be encouraged to walk about, and on no account should any splint or restricting apparatus be applied.

No. LXX.—“*Paralysis of the Kidneys.*”

I extract the following from a paper by Sir Henry Hallford (1818) :—“ There is a disease at once so dangerous and so soon fatal, that every physician should be aware of it, the paralysis of the kidney. * * * I have seen only five instances of it in twenty-seven years. The last was about two years since; and as it was an exact copy of all the others * * * I will detail it shortly.

“ A corpulent farmer, of about fifty-five years of age, was seized with a rigor. * * * He had not made water, it appeared, for twenty-four hours; but there was no pain, no sense of weight in the loins, no distension in any part of the abdomen, and therefore no alarm was taken till the following morning, when it was thought proper to ascertain whether there was any water in the bladder, by

the introduction of the catheter; and none was found. I was then called, and another inquiry was made, some few hours afterwards, by one of the most experienced surgeons in London, whether the bladder contained any urine or not, when it appeared clearly that there was none. The patient sat up in bed and conversed as usual, complaining of some nausea, but of nothing material in his own view; and I remember that his friends expressed their surprise that so much importance should be attached to so little apparent illness. The patient's pulse was somewhat slower than usual, and sometimes he was heavy and oppressed.

"I ventured to state that if we should not succeed in making the kidneys act, the patient would soon become comatose, and would probably die the following night; for this was the course of the malady in every other instance which I had seen. It happened so; he died in thirty hours after this, in a state of stupefaction.

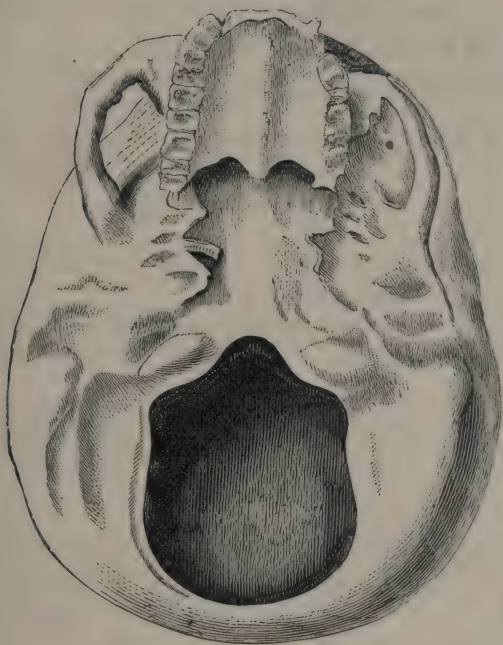
"All the patients who have fallen under my care in this disease were fat corpulent men, between fifty and sixty years of age; and in three of them there was observed a remarkably strong urinous smell in the perspiration twenty-four hours before death. Only one of them had complained of previous nephritic ailment. He had suffered frequently, and had passed several small calculi, but there was no difference in the progress of his symptoms when the paralysis had once taken place."

What was the probable nature of the disease in the cases described?

ANSWER.

The cases to which Halford gave the name of "paralysis of the kidneys" were in all probability examples of mechanical suppression of urine. These were most likely instances of single kidney, in which the ureter had got plugged by a calculus. Cases of single kidney are not uncommon. Sometimes it is a congenital condition, but more frequently one kidney has been destroyed by disease. It will be observed that Halford's statements as to his patients apply exactly to those most likely to suffer from stone. In one it is expressly stated that he had done so. The fact that the others had not does not militate much against the hypothesis suggested. I have myself recorded a case in which a gentleman died of retention with his only ureter corked by a small calculus. It was an example of congenital absence of one kidney, and this was his first attack of stone.

Mr. Clement Lucas has recently recorded a most successful case in which some months after excision of one kidney for stone symptoms of suppression of urine occurred. The pelvis of the remaining kidney was opened, and a stone found blocking the ureter. It was extracted, and the patient recovered.

No. LXXI.—*Explanation of Woodcut.*

The woodcut shows the base of a skull in which an enormous opening—such as would admit a child's fist—extends backwards from the foramen magnum. It is from a dried specimen, of an adult skull, which is preserved in the Musée Dupuytren at Paris. It is without history, but it may be plausibly conjectured that its possessor suffered from a large occipital encephalocele. There is no bridge of bone limiting the foramen magnum posteriorly, but in the recent specimen probably a strong ligamentous band crossed the space transversely in this position, and separated the spinal canal from the large orifice through which the encephalocele protruded. I have dissected several similar specimens in which this condition existed. They were all from young infants, and I am not aware of any other instance than the one to which the woodcut belongs in which a patient the subject of an encephalocele of this nature and size has survived to adult life. A

number of delineations of the conditions presented by such infants at the time of birth will be found in plate 47 of my "Illustrations of Clinical Surgery." Figure 5 in Plate XII. of Dr. Victor Bruns' Surgical Atlas shows a very similar base of skull, together with an outline portrait of the conditions presented during life. The patient was, however, as usual, an infant at the time of death.

No. LXXII.—*Mumps.*

The following points require further investigation in reference to epidemic mumps:—

When both sexes are equally exposed to contagion, do males always suffer most severely? Do they suffer more frequently than females?

What are the earliest ages at which it may occur?

Is its severity usually in ratio with the age, being greater in the older?

Do elderly persons ever suffer?

Is the evidence of inflammation of the ovaries ever definite, and when the complication arises are both ovaries usually affected?

Are the testes ever affected in young boys?

When head symptoms occur, is there usually pericarditis?

What are the conditions as regards brain and heart found after death from mumps?

Is there ever reason for believing that the disease has spread from the lower animals (cats, horses, &c.)?

After mumps is there any evidence of wasting of the parotids, as is so common in the case of the testes?

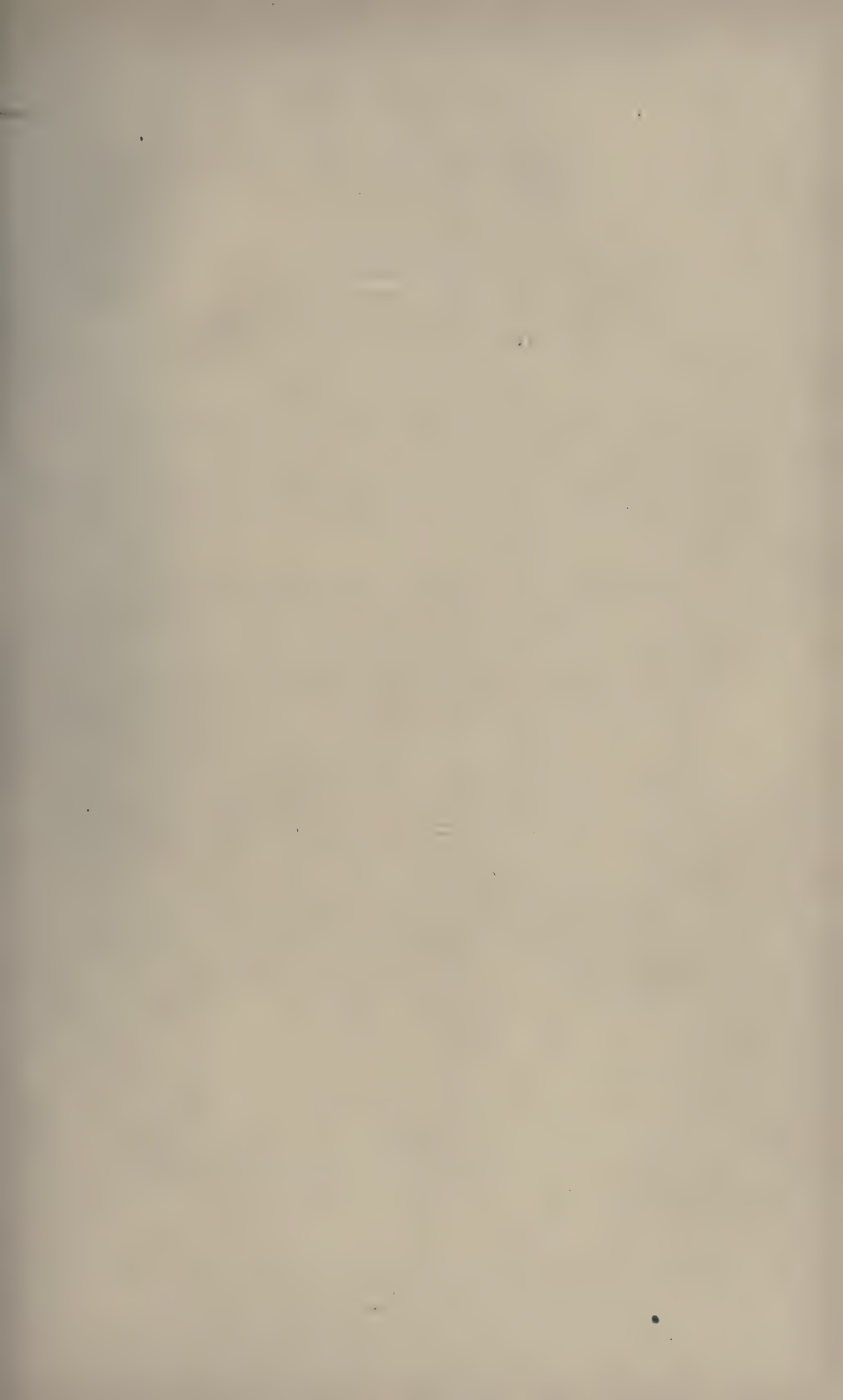


PLATE XVIII.

ARSENIC-PSORIASIS AND KERATOSIS.

THE back and front surfaces of the hands of Mr. D——, the patient whose elbow is shown in the next Plate. It will be seen that across the knuckles of the hand a number of dry, thick, scaly crusts have formed. On the backs of the fingers there are numerous little pits where the epidermis is broken, while the skin generally is discoloured and harsh. The patches across the knuckles are exactly like psoriasis, excepting, perhaps, that there is more thickening beneath the crusts. They do not occur precisely in the parts where psoriasis is most common, that is, on the back of the hand, rather than the knuckles. The palmar surface of the hand shows the epidermis dry and cracked, and there are numerous little pits where it has been broken. The extremities of the fingers are especially affected and somewhat reddened. It has been difficult to represent the little corn-like patches of thickened epidermis which were present.





PLATE XIX.

ARSENIC-PSORIASIS.

THE Plate shows the elbow of a gentleman whose hands are delineated in Plate XVIII. It will be seen that the whole skin is of a dirty brown tint, and that a large scaly patch has been developed near to the elbow. This patch was quite dry, but it was somewhat less circumscribed, and showed more of redness about its edges than common psoriasis usually does. The patient had a perfectly healthy skin previous to the administration of arsenic.

The arsenic had been given in the hope of arresting a malignant growth.





PLATE XX.

ARSENIC-KERATOSIS.

THE palmar surfaces of the two hands of Dr. W——, who became the subject of arsenic-cancer. It will be seen that the palms are exactly like that of the hand shown in Plate XVIII., but with the addition of a fungating growth in each. That in the right palm is of considerable size and thickness, and is placed just above the wrist. That in the left is much smaller, having been of more recent development, and shows only a reddened excoriation between the index and middle fingers, beneath which there is a certain amount of thickening. In this case common psoriasis had been present in the first instance, and arsenic had been given in large doses over a long time for its cure.

After this portrait was taken, Dr. W—— had his right hand removed by amputation through the forearm. He died within a year, with recurred malignant growths in the glands and viscera. The form of cancer was a modification of epithelial.



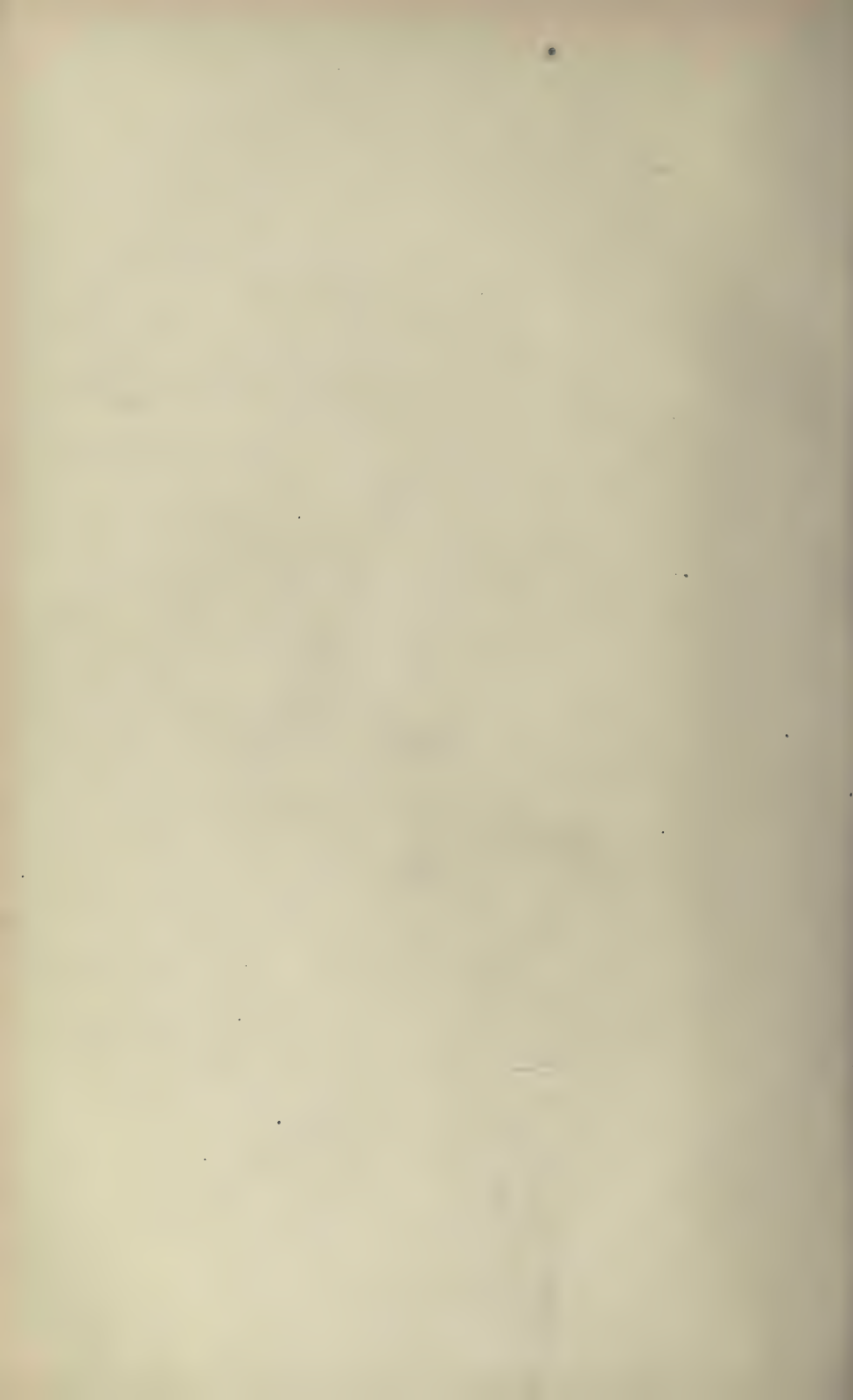


PLATE XXII.

DESQUAMATIVE DERMATITIS CURED BY OPIUM.

THE patient from whose left hand this drawing was made was a woman aged sixty-one, fairly developed, and (apart from the eruption) in excellent health. Both hands and feet, the scalp, the groins, the corners of the mouth, and the canthi of the eyelids were affected by a chronic exfoliative dermatitis, which had commenced nine months before, in the form of red spots between the fingers, and three months later had attacked the toes. No cause could be assigned, and there was no history of skin-diseases in the family. Her tongue was very clean and red, almost "beefy." Both hands and feet were attacked in a precisely symmetrical manner; on the latter all the toes were affected, but the disease did not extend much above them. All the nails were inflamed and rough. The disease tended to spread from the digits upwards. On the backs of the wrists and on the neck there were a few small detached patches, and these were increasing in number; they also showed a strong tendency to advance at their edges. They were for the most part quite dry, were attended by peeling of the epidermis and by some slight swelling, and tended to form fissures. When the scales were removed by applications the surface left was smooth, raw-looking, and red. The scalp was everywhere involved, and the hair very thin. There were symmetrical patches at the corners of the mouth, which were gradually extending, with abrupt margins, on to the cheeks. The inner commissures of the eyelids were also affected, and there were symmetrical patches on the groins.

The patient had undergone much skilled treatment before I saw her; arsenic had been freely used, and, amongst other measures, she had been salivated. A complete cure finally resulted under the use of opium. The hair grew again, the nails were completely restored, and the skin of the hands became soft and healthy. I do not think that there could be the least doubt as to the opium being really the cause of the recovery. It was continued for upwards of three months. The dose was from five to fifteen minims of the *Liquor Opii Sedativus*. The patient regained good health, and remained well several months after the opium was disused. Six months later there was a slight tendency to relapse, but she again recovered.





PLATE XXIII.

ERYTHEMA-URTICARIA FROM VEST-IRRITATION.

It might, perhaps, be useful if a classified arrangement of the causes of skin disorders were attempted, in addition to endeavours to group the diseases themselves. There are certain eruptions to which the term "Vest-Eruption" is more practically appropriate than any which should attempt to designate the character of the rash itself. They come in consequence of the irritation of the vest, and usually of a flannel vest. Sometimes it is the case that the patient has recently adopted some new material, or changed from his thin summer garment to a thicker one for winter. Vest-rashes are usually limited to the parts touched by the vest, but they are by no means always the same in character. Sometimes they show a tendency to spread to other adjacent parts.

In the portrait is shown the chest of an adult man, who had been working hard in very hot weather with a woollen vest on. He had perspired very freely indeed, but had not dared to put aside his vest for fear of catching cold. The result was a profuse erythematous-urticaria over all parts where the vest touched. The eruption, as shown, was in margined patches raised at their borders, of a bright red tint, whilst their centres were pale and depressed. It differed from a true urticaria in the persistence of the individual patches, and its limitation to the parts which had been irritated. It soon got well on removal of the cause. In other cases, vest-eruptions may present features very different from those here shown. An excellent Portrait, in 'Wilson's Atlas,' shows a lichenoid eruption, exactly limited to the vest regions. No doubt it was of the causation above described.

Vest-eruptions form an important group of the class of "Skin diseases due to the irritation of clothing."



PLATE XXV.

FIG. 1.—CANCER OF THE MALE BREAST.

FIG. 2.—CANCER OF BREAST, WITH CYSTS AND
ADENOID GROWTH.

THE upper figure shows the section of the breast of an old man with a mass of scirrhus in the centre. The nipple is deeply retracted, and by its side is a small cyst-cavity containing greenish fluid. The scirrhus mass is very dense, pale and fibrous-looking. It puckers-in the surrounding fat, and apparently involves almost the whole gland.

The patient was an old gentleman of seventy-four, who had known of the tumour for six months before its removal (Feb. 15th, 1870). I believe that he remained well after its excision, and had no recurrence.

The lower figure shows the section of the breast of Mrs. C., aged fifty-four, in whom scirrhus was developed, together with cystic and adenoid disease. She had had a sore nipple for two years, but had noticed a tumour only eight months. To the left is seen a congeries of cysts, which contained blood-stained fluid and soft endogenous growths. Above the cysts is a circumscribed mass of adenoid growth, and to the right of the latter the structures are puckered by infiltrating scirrhus.

The illustration is of value as enforcing the desirability of excision of the whole breast in all cases of cystic disease in which induration remains after evacuation of the cyst-contents. It may perhaps be said that in all cases in which the cyst-contents are blood-stained, or other than perfectly clear, excision ought to be done. In this instance a large quantity of cyst-fluid had been evacuated by tapping some weeks before the operation.



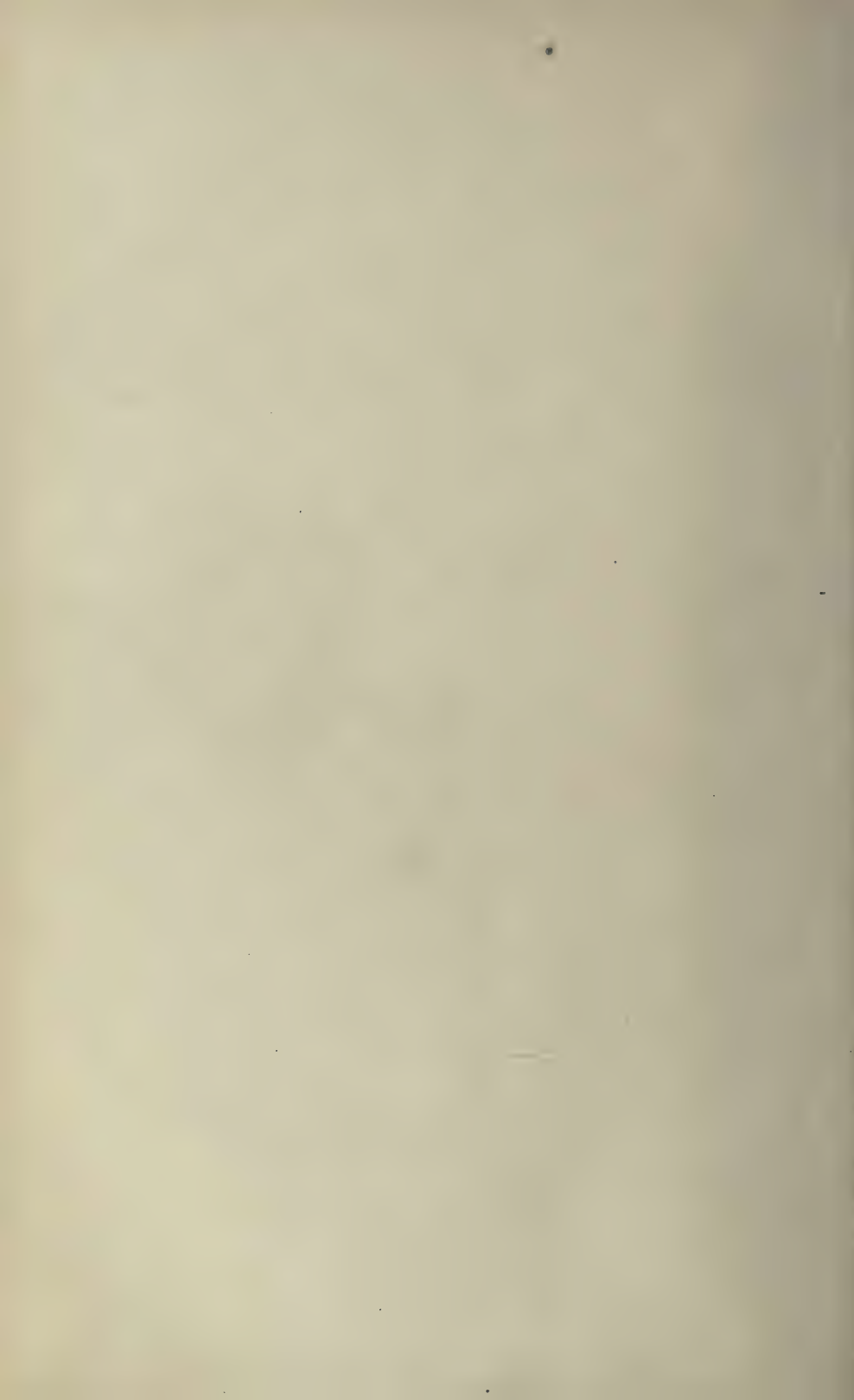


PLATE XXVI.

RAPIDLY GROWING SCIRRHUS OF THE BREAST.

THE drawing shows a large, well-circumscribed mass of scirrhus in the middle of a breast loaded with fat. The growth was unusually soft and vascular, and had developed very rapidly. It shows large areas of yellow fatty degeneration.

I have lost the address of the patient (who was a woman of middle age), and cannot speak positively as to recurrence; but I believe that she was living several years after the operation, and free from symptoms. My experience has been that some of these cases of most rapidly growing tumours of the breast have given the best results as regards non-recurrence.





PLATE XXVII.

MYELOID AND CYSTIC TUMOUR OF THE FEMUR.

THIS portrait represents the section of a tumour which had developed slowly in the condyles and lower part of shaft of the femur. The patient was a man of about twenty-eight, and the tumour had been growing several years. I amputated through the thigh (in the London Hospital), and he made a good recovery. He is, I believe, still living (ten years after the operation).

The portrait shows the condyles and shaft expanded by a well-defined and partially encapsuled growth. The section shows, in the solid parts, the various tints of brown and yellow which characterize myeloid sarcoma. There are numerous cysts of considerable size, and many nodules of ossification. The tumour bulges into the knee-joint, so as to appear to occupy it. It is everywhere surrounded by a thin capsule of bone.

As illustrating the law under which similar growths occur under similar conditions, I may mention that I possess another drawing, which can scarcely be distinguished from this.

See 'Illustrations of Clinical Surgery,' plate LVIII.



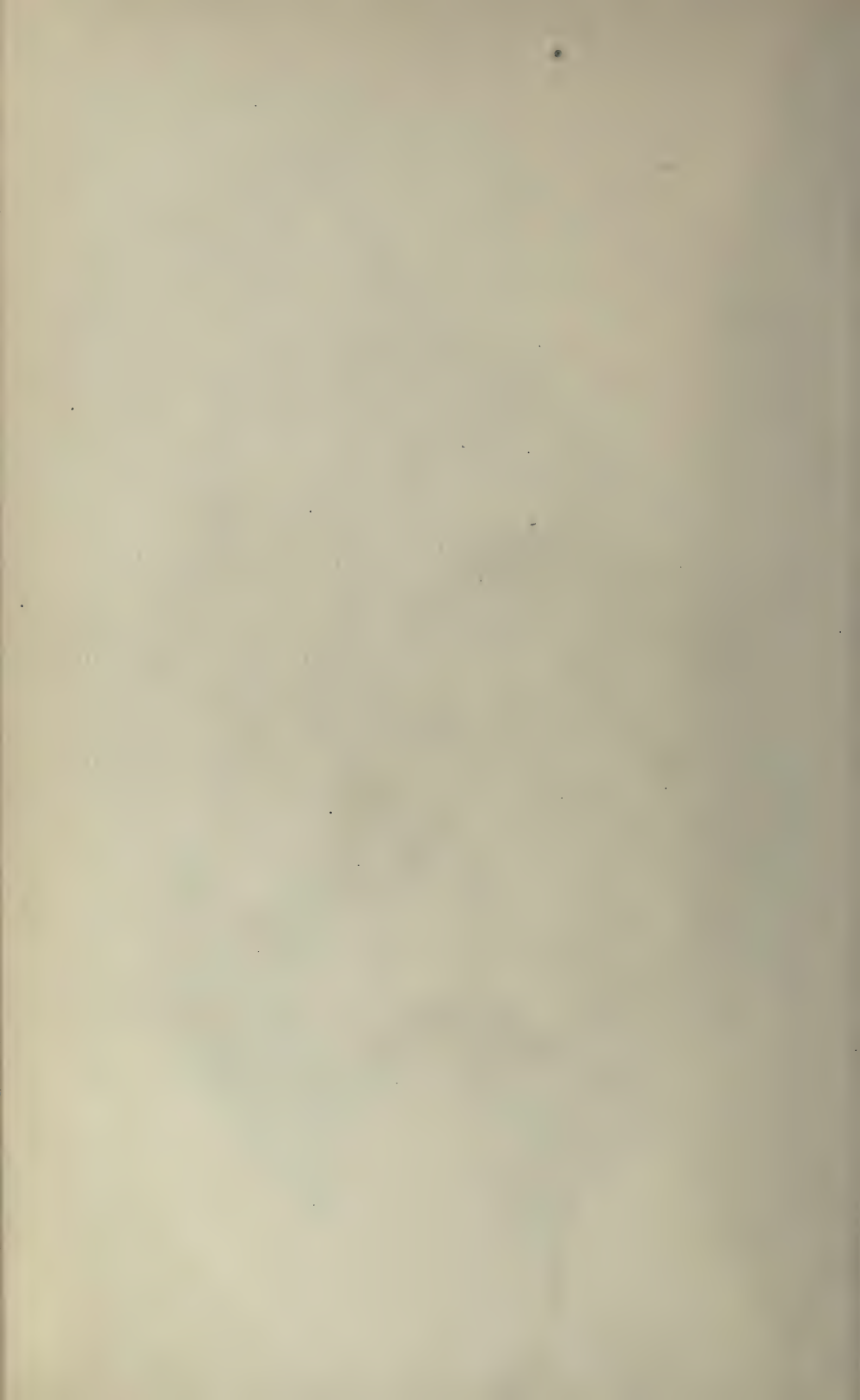


PLATE XXIX.

FUNGATING GROWTH ON SCALP.

THIS portrait shows the condition of the scalp in an elderly woman, in whom large masses of firm fungoid granulations had been produced, as was believed, secondarily to ulceration of a sebaceous cyst. There was, however, no clear evidence as to its earliest stage. The patient was under Mr. Rivington's care in the London Hospital, by whom the whole of the diseased growth was excised. The operation was done chiefly by means of Paquelin's cautery, but was attended by very profuse hæmorrhage. The wound healed well, and five years later there had been no return of the disease. At this latter date the patient, then seventy-three years of age, was under my own care in the London Hospital on account of senile gangrene of one foot, and made a good recovery after amputation through the thigh.

A microscopic examination of the parts removed showed conditions which were not easily distinguished from those of epithelial cancer. There had, however, never been any gland disease, and the fact that no tendency to recurrence was shown after the removal of such an extensive growth proved that the vital endowments of the tissue must have been very different from those of most forms of epithelioma. The tendency to fungate without any deep ulceration was the peculiar feature of the case. It belongs, I have no doubt, to the group of cases which Mr. Cock described many years ago in the Guy's Hospital Reports as occurring in connection with enlarged sebaceous follicles of the scalp. Mr. Cock has not, however, described any case in which the disease at all approached in extent that shown in this drawing. Its extent might indeed have been almost held to be a bar to operation, and the successful result is certainly an encouragement to surgical energy even under unpromising conditions.

This case has already been published as Plate LXIX. in my "Clinical Illustrations."



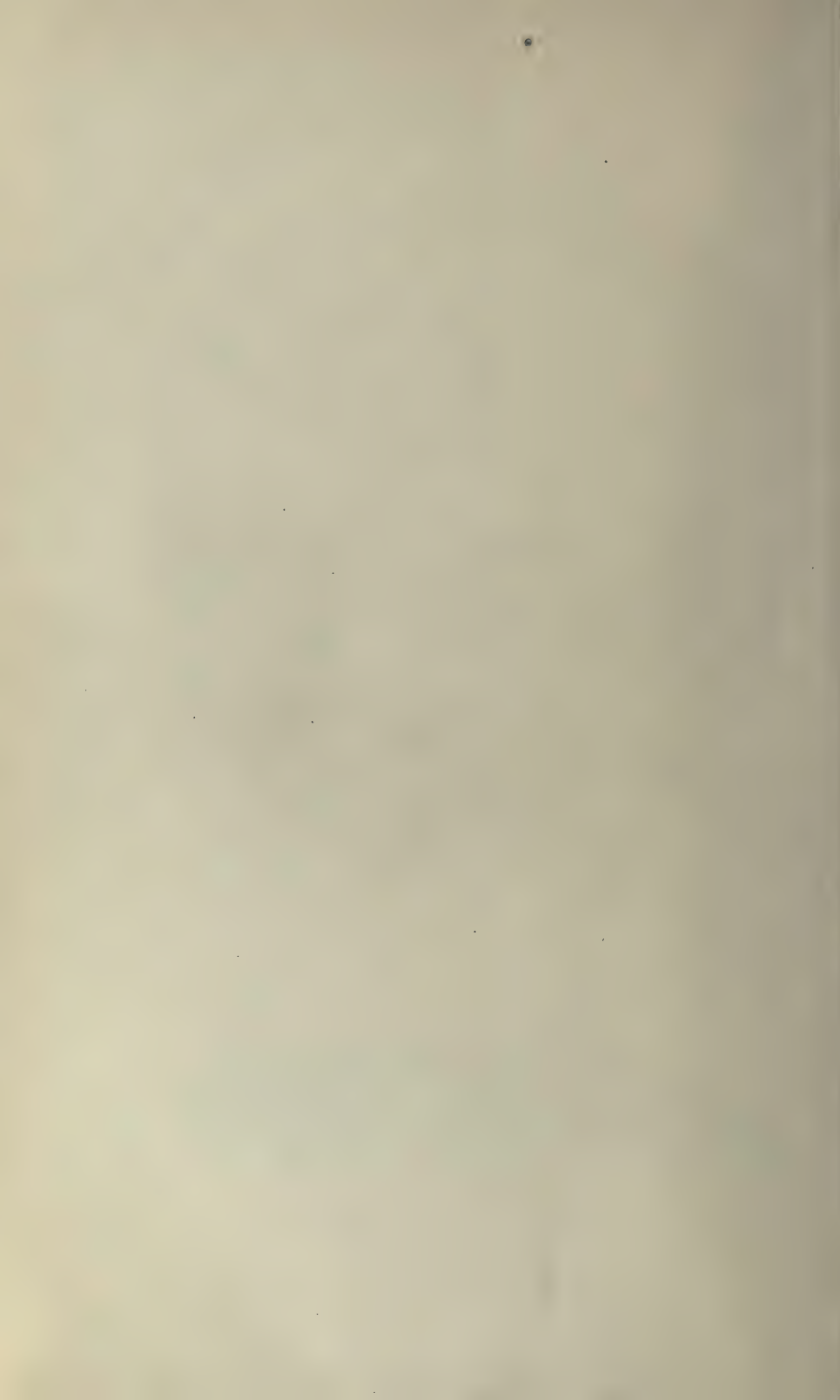


PLATE XXXIII.

TUBERCULAR SYPHILITIC-LUPUS.

THIS portrait exhibits the condition which was present in a woman who was under my care in the London Hospital, suffering from tertiary syphilis. It is a good example of the tubercular form of syphilitic lupus. That it was really syphilitic was proved by its complete disappearance under specific treatment. It will be seen that on the chest and fronts of shoulders there are large areas of superficial scar; and after the cure was complete the patient's face was left in a similar condition. The whole of the face as seen in the portrait is covered with elevated, tuberos masses. These are of very variable sizes, and in many instances have become confluent. They differ only from those of true lupus in that they present none of the brownish semitransparent material to which the term "apple-jelly" is appropriate. The occurrence of the disease in scattered patches on the chest, and the completeness of its cure in many of them, are also features which strongly suggest a diagnosis of syphilis.

I do not see any reason for attempting to avoid the expression "syphilitic-lupus." In the late stages of syphilis we undoubtedly meet with a great number of cases of lupus-like affections of the skin in which it is very difficult indeed to determine whether the disease is of specific origin or not. There are of course minor features of difference which aid the diagnosis, but not unfrequently the history of the case is what we have chiefly to rely upon. All the different forms of lupus vulgaris and lupus erythematosus may in turn be simulated. The most frequent is the serpiginous form, which creeps at the edge and heals in the centre, and to which the old name of "horse-shoe sore" is applicable. The portrait here given is not of that form, but of a much less common one. It corresponds to certain cases of lupus vulgaris, also not very common, in which numerous isolated patches or tubercles are produced. These are chiefly of the nature of satellites, as regards the parent one, and they in turn are productive of others. It was to this form, among the older nosologists, that the term "tubercular lupus" was applicable.



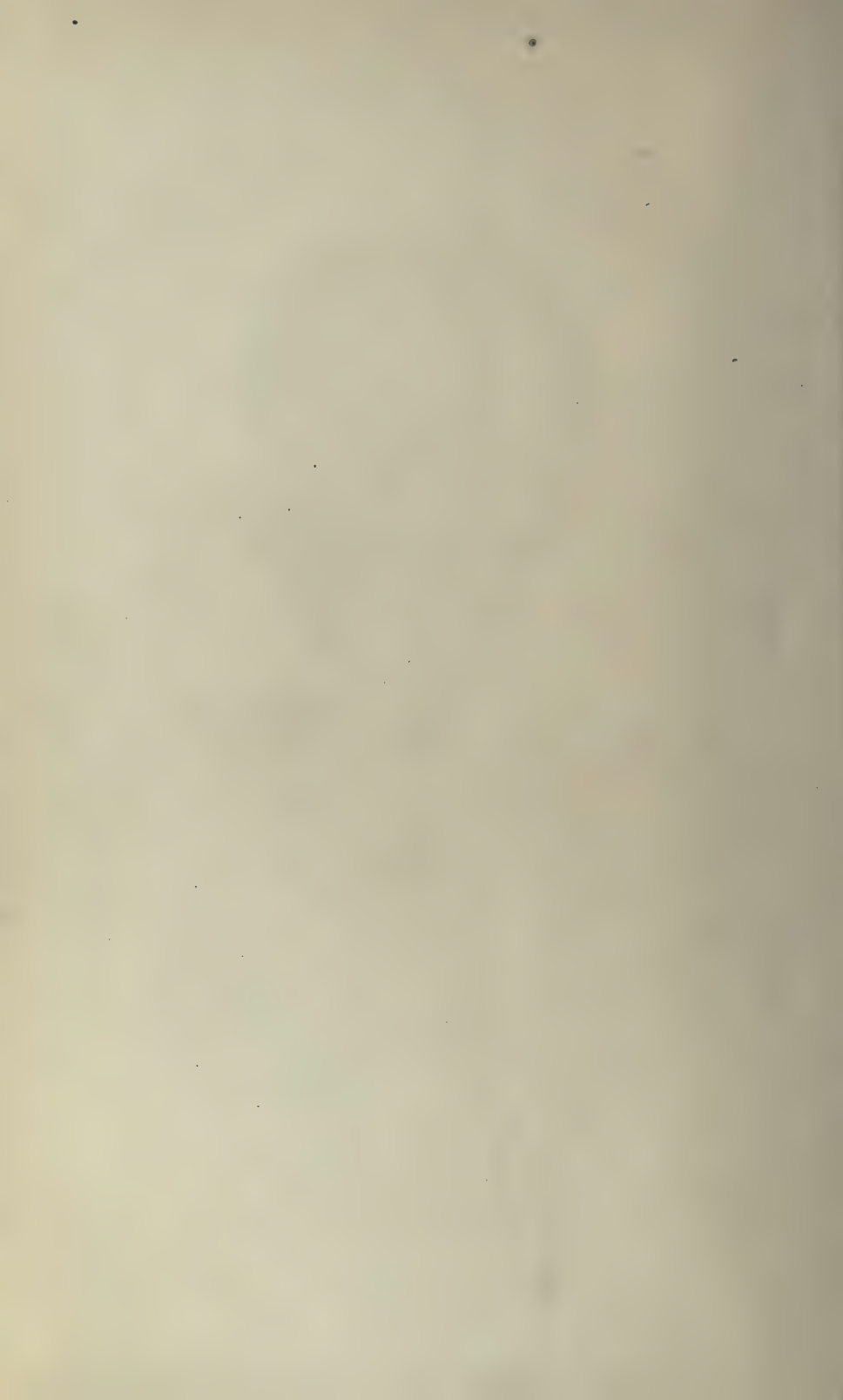


PLATE XXXIV.

SUPERFICIAL RODENT CANCER.

THIS portrait exhibits the condition produced by rodent carcinoma when it travels superficially over a large extent of surface, and nowhere shows any tendency to grow deeply. A large part of the temporal, frontal and nasal regions are seen to be involved. Attention is to be particularly given to the character of its edge, which is a sinuous elevated roll, everywhere alike. A careful inspection of the peculiar characters of this narrow wavy border will in almost all cases enable the observer to make a correct diagnosis of rodent ulcer.

It will be noticed that not only is there no deep ulceration anywhere, but that there is no development of papillary growths or granulation masses. The disease consists simply of the narrow "rolled" edge, which is steadily aggressive, and disorganises the skin, but leaves an ulcer which may soon cicatrise behind it. These extremely superficial conditions are exceptional in rodent cancer, and in all cases they are probably only temporary. Sooner or later the disease tends to pass more deeply. Nor is the absence of tendency to fungate and develop papillary excrescences by any means constant. In the present instance the patient was a woman of about thirty-five, much younger than the ordinary subjects of rodent. The disease had been in progress six or seven years.





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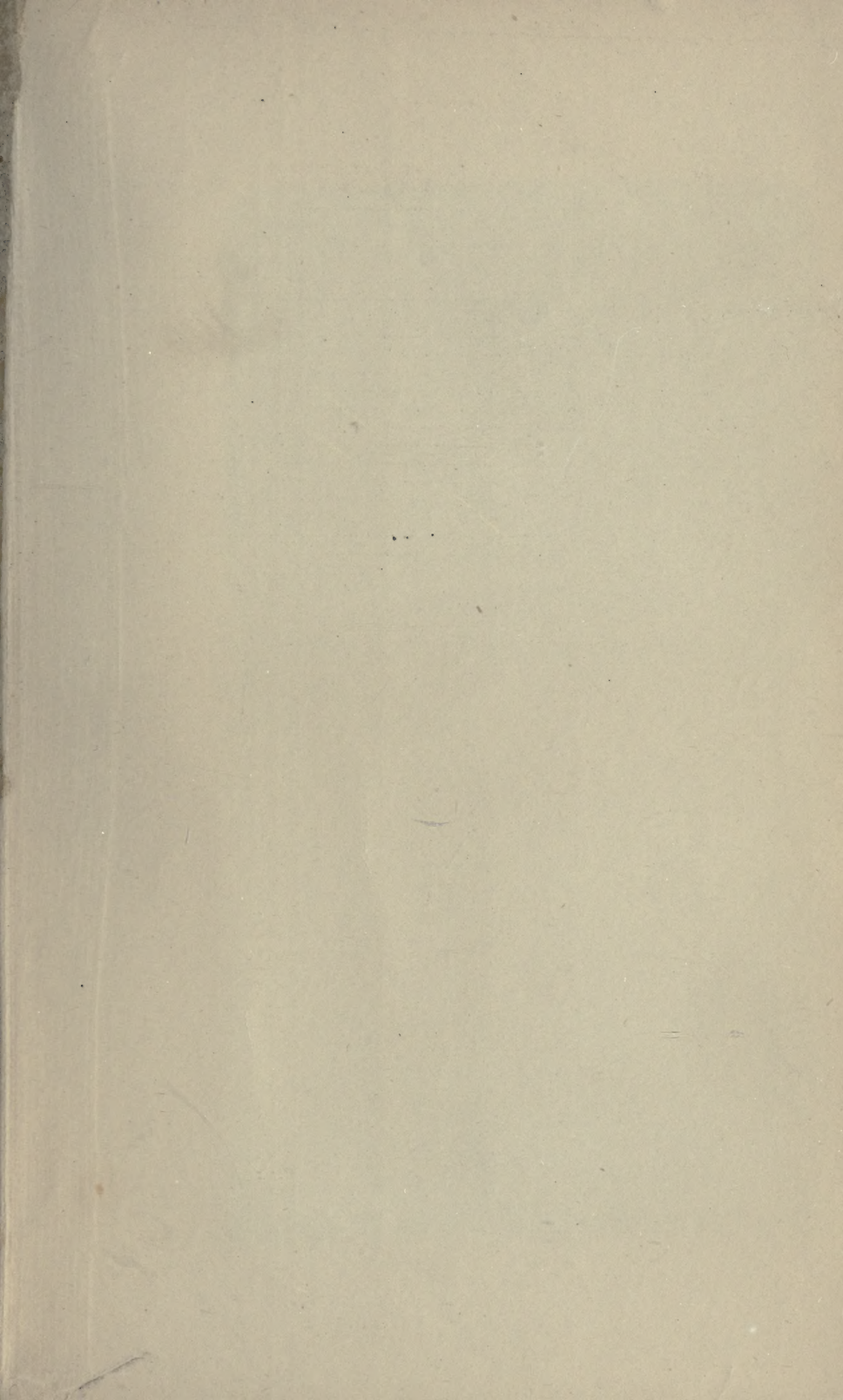
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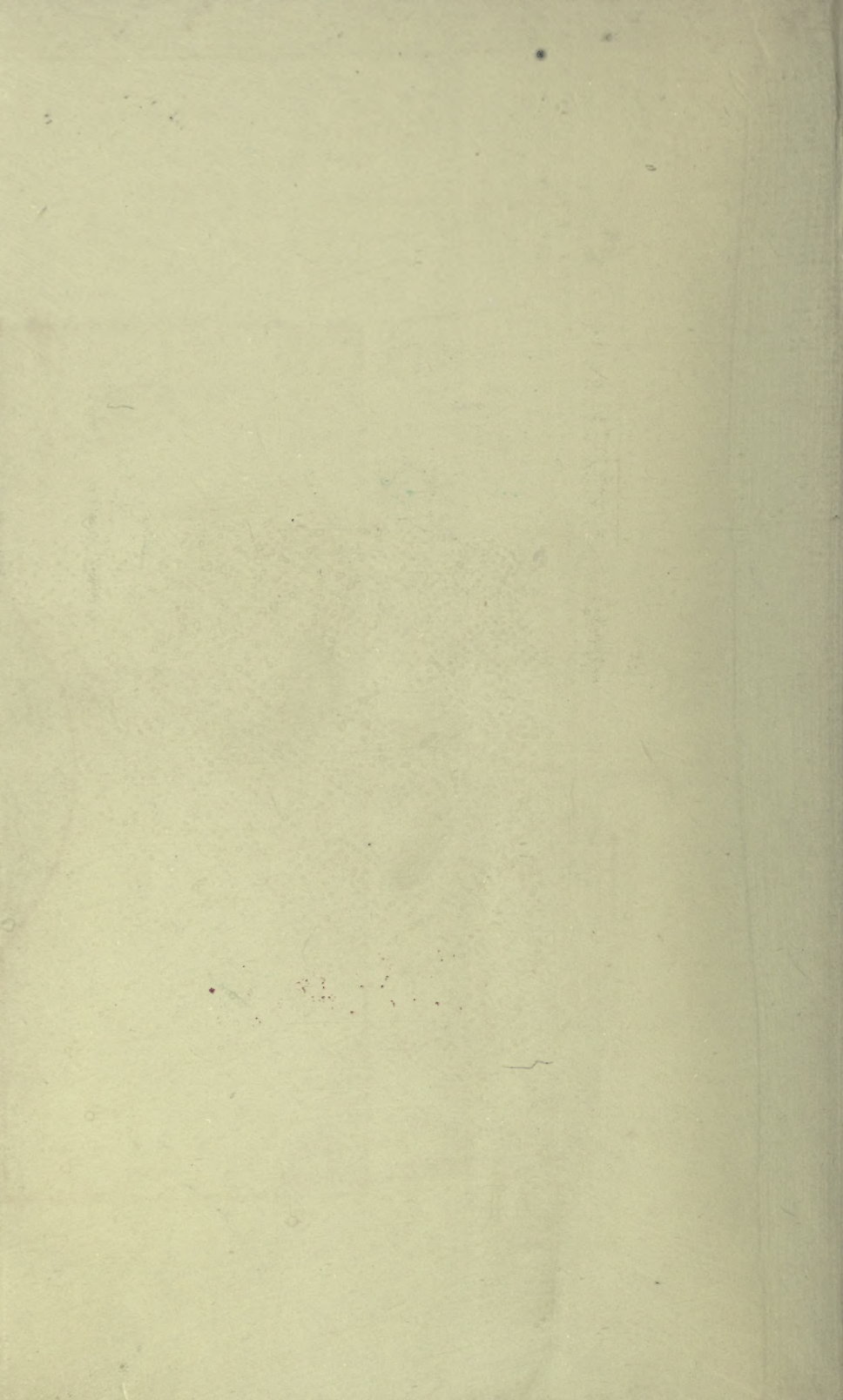
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